



SURPRISE MEDICAL BILL LAWS AND OUT-OF-NETWORK COVERAGE ISSUES

National Coordinating Committee for
Multiemployer Plans
Annual Conference
September 24, 2019



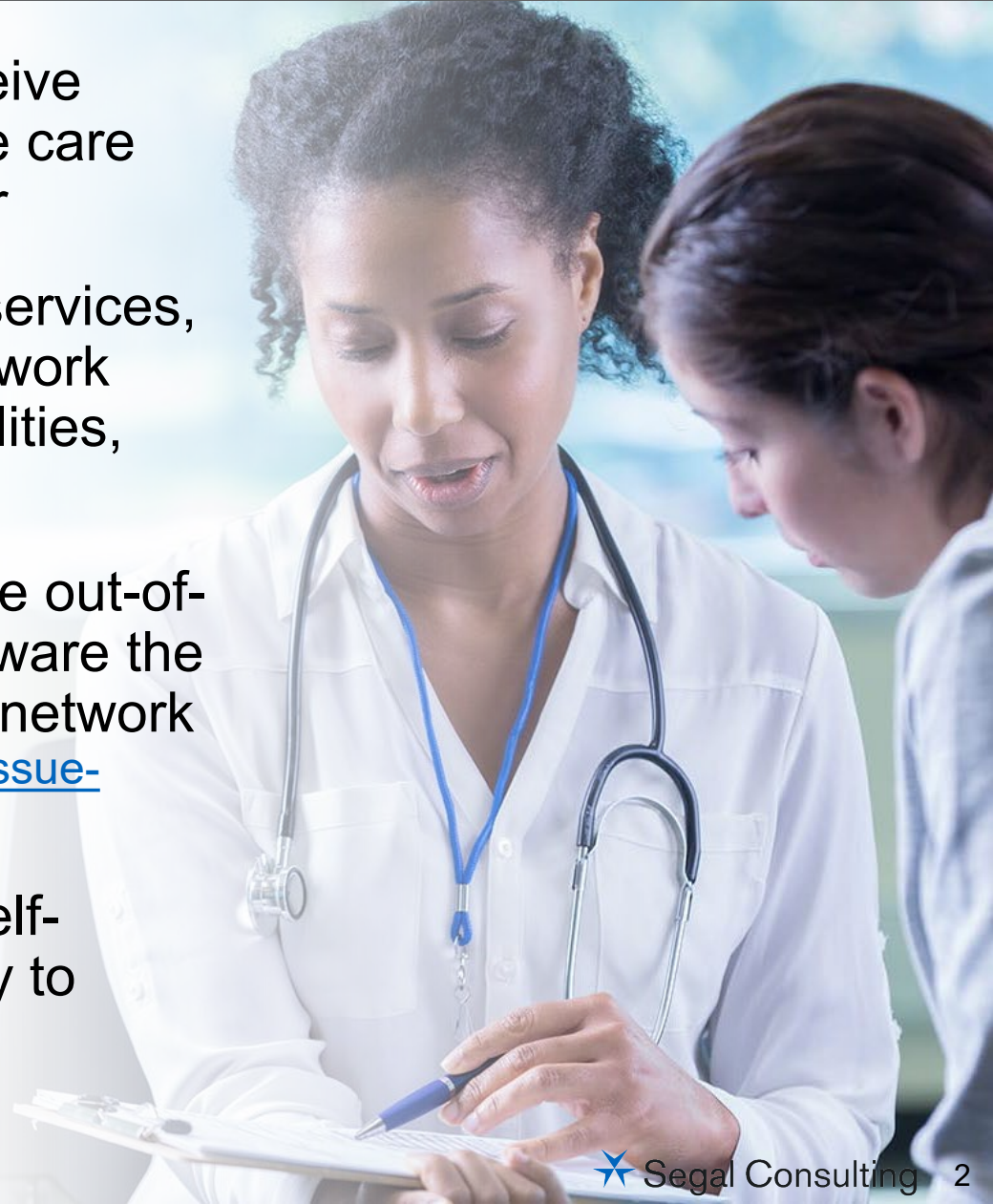
★ Segal Consulting

What we will cover:

- What are Surprise Medical Bills?
- Overview and Current Status of Federal Surprise Medical Bill
- The Legal Framework related to non-network reimbursement
- Terms related to non-network health plan claims
- Prevalence of non-network claim utilization
- Potential Implications of the Surprise Medical Bill
- Ways to help avoid abuse by certain types of non-network providers

Surprise Medical Bills

- These are bills that people receive when they inadvertently receive care from an out-of-network provider
- Examples include emergency services, services provided by out-of-network professionals at in-network facilities, and ambulance services
- 70% of people with unaffordable out-of-network medical bills were unaware the provider was not in their plan's network
<https://www.kff.org/private-insurance/issue-brief/surprise-medical-bills/>
- Federal legislation applies to self-insured plans. State laws apply to insurers and providers

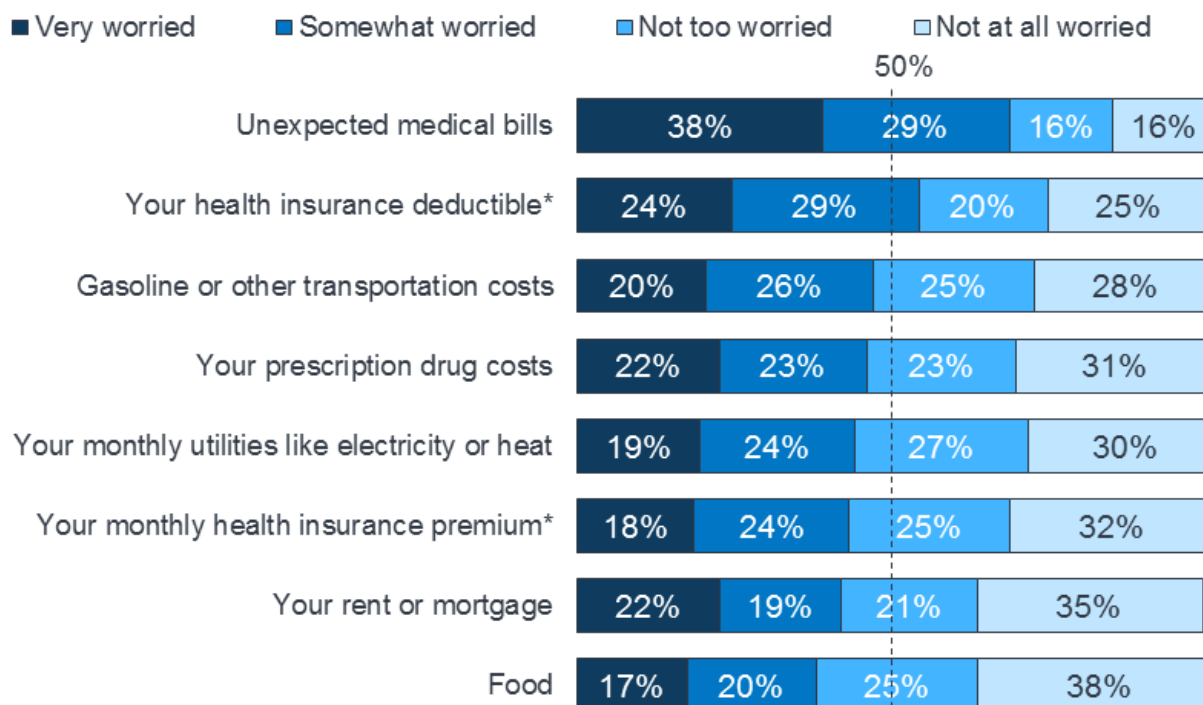


Large Majority of Public Worried About Surprise Bills

Figure 7

Large Majority Are Worried About Being Able To Afford Surprise Medical Bills For Them And Their Family

How worried, if at all, are you about being able to afford each of the following for you and your family?



NOTE: *Among insured. "Not applicable (Vol.)" and Don't know/Refused responses not shown. Question wording modified. See topline for full question wording.

SOURCE: KFF Health Tracking Poll (conducted August 23-28, 2018)



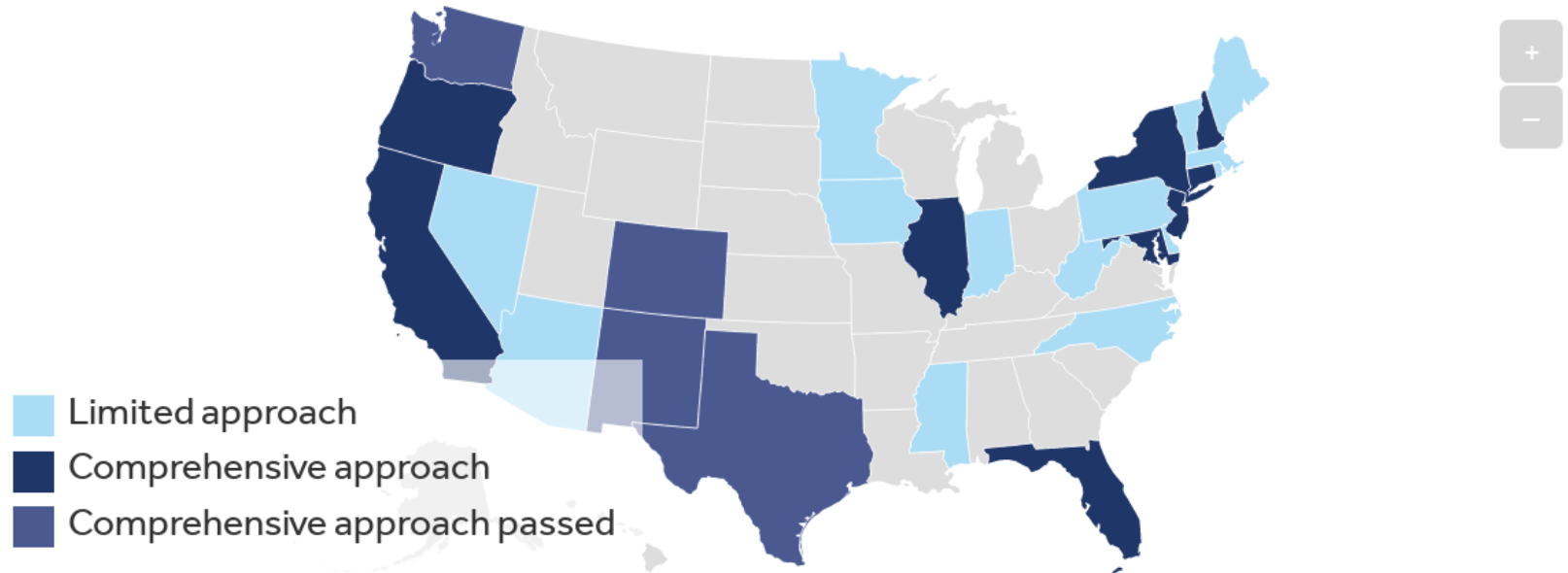
State Laws: Surprise Medical Bills

➤ Some States have enacted “Surprise Bill” laws

- Surprise bill laws only able to regulate insurers and HMOs, not self-funded plans.
 - **2015: New York** state law protects participant who uses an out of network specialist; uses arbitration
 - **2016: Connecticut** state law protects from surprise bills from a health insurer for an out-of-network service. Participant only required to pay the coinsurance, deductible, or other out-of-pocket expense that would be required if the services were performed by an in-network provider.
 - **2017: California** state law protects from surprise medical bills from non-network providers who work at in-network facilities such as hospitals, labs or imaging centers.
 - **2018: New Jersey** state law protects from being balance billed for ER/Urgent care visit and certain inadvertent non-network use like a non-network lab. Self-funded plans can opt into this legislation, but most do not.
- Also, about 25 states have laws requiring insurance companies/HMOs to protect patients from balance billing by non-network providers in an ER or in a network hospital.
- **2019: Massachusetts** Complaints about out-of-network charges represented >35% of claims filed with the Attorney General’s Office. A recent settlement required certain organizations to better notify patients of fees. Attempts at a MA Surprise Bill law have been stopped by disagreements over how to determine out-of-network rates.

State Balance Billing Protections

State balance billing protections for state-regulated plans



Note: Four states have passed comprehensive protections that have not yet gone into effect as of June 2019

Source: See Jack Hoadley, Kevin Lucia, and Maanasa Kona, "State Efforts to Protect Consumers from Balance Billing" for summary of state laws enacted through 2018. Updated by KFF to reflect action as of June 2019.

• [Get the data](#) • [PNG](#)

Peterson-Kaiser

Health System Tracker

Federal Law: Surprise Medical Bill Momentum Builds

- White House event on May 9, 2019, followed by press statements from Chairs/Ranking Members of key committees promising bipartisan action
- Most proposals will hold patients harmless for bills
- New methods would be used to set non-network reimbursement

What Claims would Surprise Bills Not Address?

- Targeted at situations where consent is not possible or meaningful
 - Emergency services at out-of-network facilities
 - Ancillary services (e.g., anesthesiologists, pathologists, labs, emergency medicine providers) rendered during a visit at a participating facility
 - Other non-emergency services at in-network facilities unless detailed notice and consent requirements are met

- Does not address other key drivers of out-of-network charges:
 - Residential treatment facilities providing substance use disorder treatment
 - Facilities that market non-network services to participants
 - Air ambulance companies

Out-of-Network Reimbursement Legal Framework

- **Certain laws limit flexibility of out-of-network reimbursement strategies**
- Affordable Care Act requires NON-GF plans to implement **special payment for emergency services in an emergency room**

ACA mandates that for a non-grandfathered plan for emergency services performed in a non-network emergency room (ER), the Plan's allowance for ER visit facility fees and ER professional fees MUST pay the greater of:

- the negotiated amount for Network providers (the median amount if more than 1 amount to Network providers), or
- 100% of the Plan's usual payment (Allowed Charge) formula (reduced by in-network cost-sharing) or
- (when such database is available), the amount that Medicare Parts A or B would pay (reduced for cost-sharing)

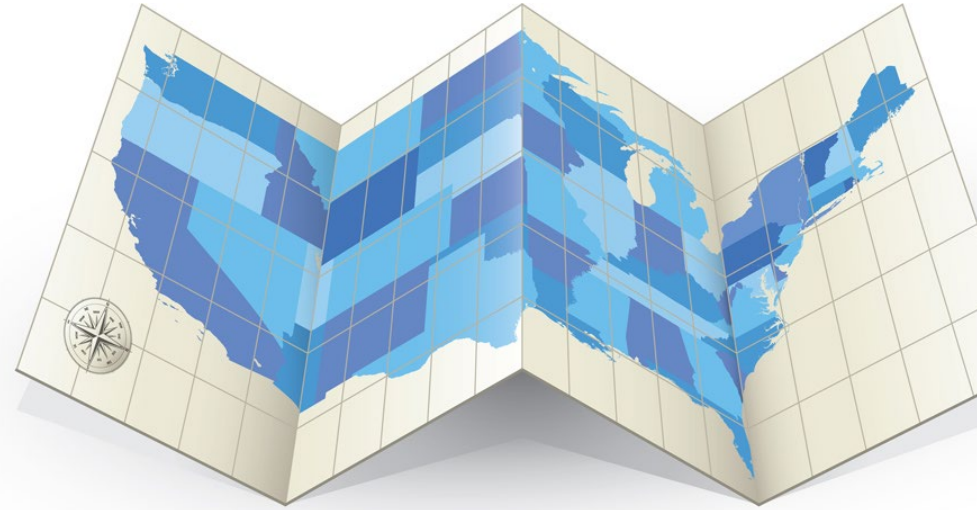
Out-of-Network Reimbursement Legal Framework

- **Mental Health Parity and Addiction Equity Act (MHPAEA)** prohibits financial requirements or non-quantitative treatment limits (NQTL) for Mental Health/Substance Use Disorder (MH/SUD) benefits that are more restrictive than the predominant financial requirements/treatment limits for Medical/Surgical benefits.
- **Network providers are prohibited from waiving patient cost-sharing** by their Network Contracts.
- The practice by any provider, including a non-network provider, **of routinely waiving patient cost-sharing** (deductibles, copays, coinsurance) could implicate:
 - Medicare
 - the Federal Anti-Kickback Statute,
 - state laws related to fraud or deceptive trade practices



“Out-of-Network” Goes By Many Names

- Out-of-Network (OON)
- Non-network
- Non-contracted
- Non-participating, Non-par
- Non-preferred
- Non-PPO, Non-EPO, Non-HMO
- Out of Area



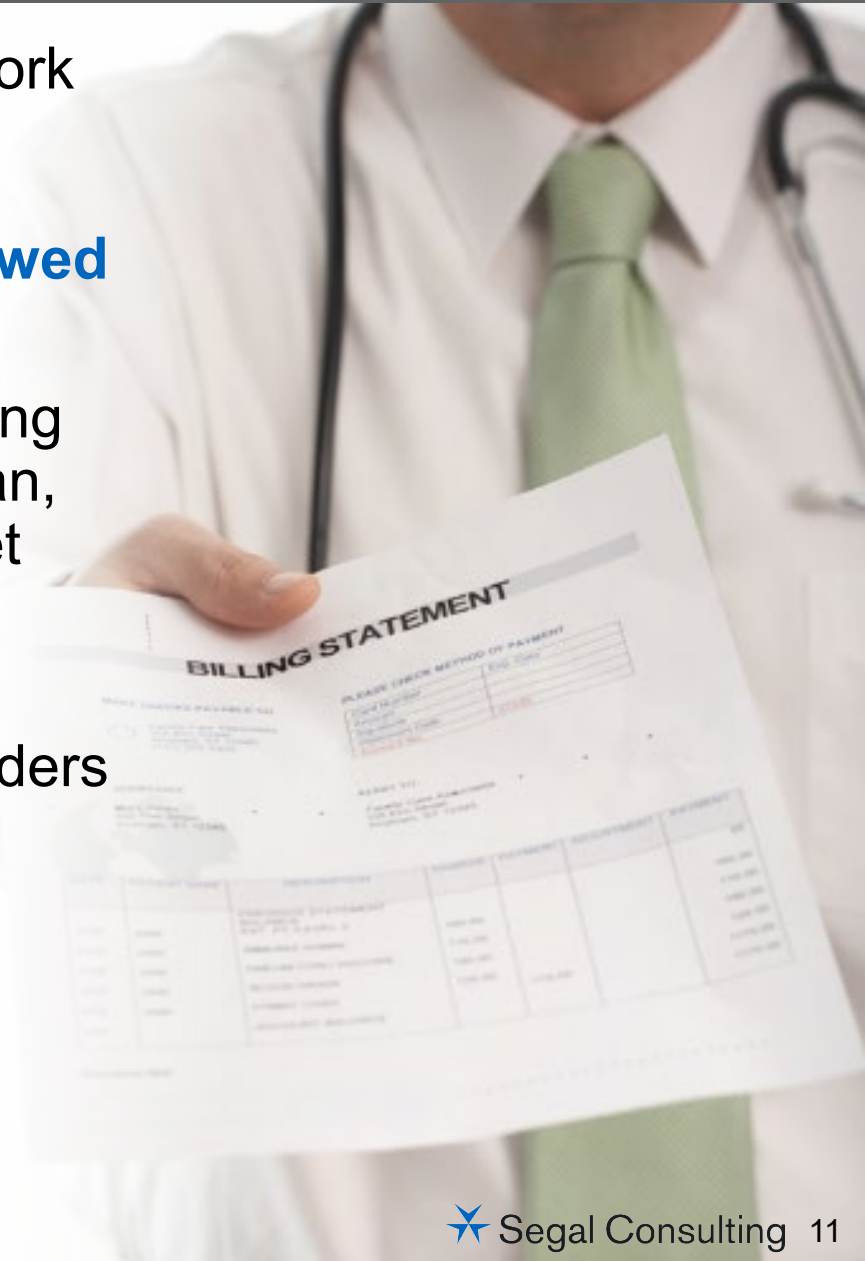
Out of Area refers to members who **reside outside the network service area**. Sometimes plan design cost-sharing is adjusted to be more favorable to members who, because of where they live, are unable to reach a network provider... nevertheless, out of area providers ARE out-of-network providers

Out-of-Network means the provider (doctors, hospitals, laboratories, home health, medical equipment vendors, health care facilities, ambulance, etc.) **does not have a contract with the network** and is not obligated to provide services at a pre-negotiated reduced/discounted price and are free to balance bill as desired.

Balance Billing

Balance billing refers to the non-network provider's **practice of recouping the monetary difference between their billed charges and the amount allowed as payment by the Plan.**

- Amounts associated with balance billing **are almost never covered** by the Plan, even if the Plan's annual out-of-pocket maximum is reached.
- Generally, plan sponsors can avoid balance billing by using network providers



Why do claims occur Out-of-Network?

Out-of-Network Claims Happen for a Variety of Reasons

Patient Factors:

- Emergency situation (ambulance takes patient to non-network location)
- Traveling outside the network service area (vacation, business)
- Temporarily residing outside the network service area (full-time students)
- Personal preference to visit a non-network provider (e.g., wanted 2nd opinion, provider was more convenient, previous relationship with provider, provider recommended by others)

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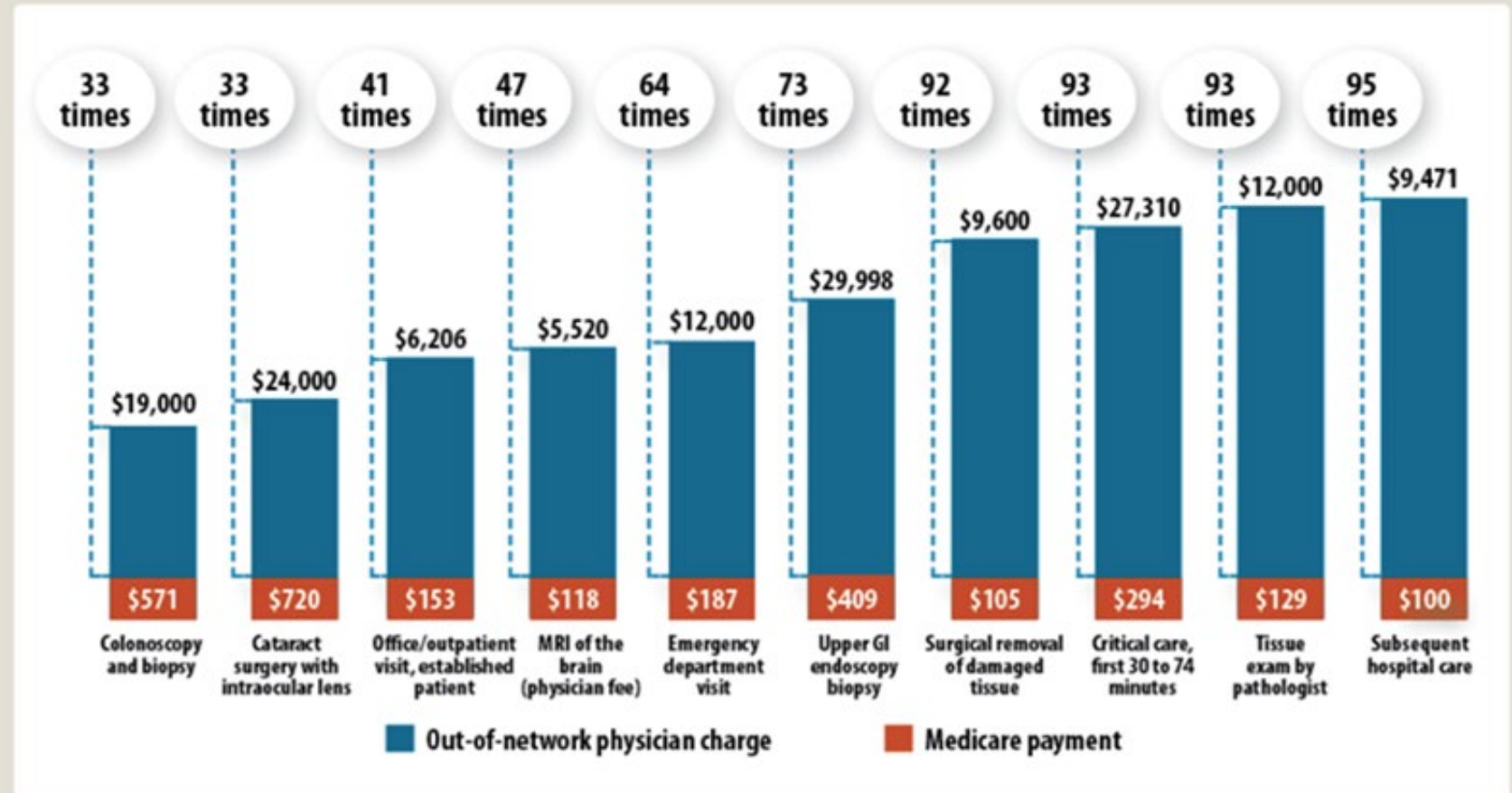
Provider and Network Factors:

- Rural/remote/ancillary service providers who are unwilling to sign PPO contracts for a variety of reasons
- Network “Gaps” for specialty care
- Provider Can Increase Income



Sample Out-of-Network professional fees

Highest reported out-of-network provider charges compared with Medicare payments for 10 common medical procedures



Source: America's Health Insurance Plans

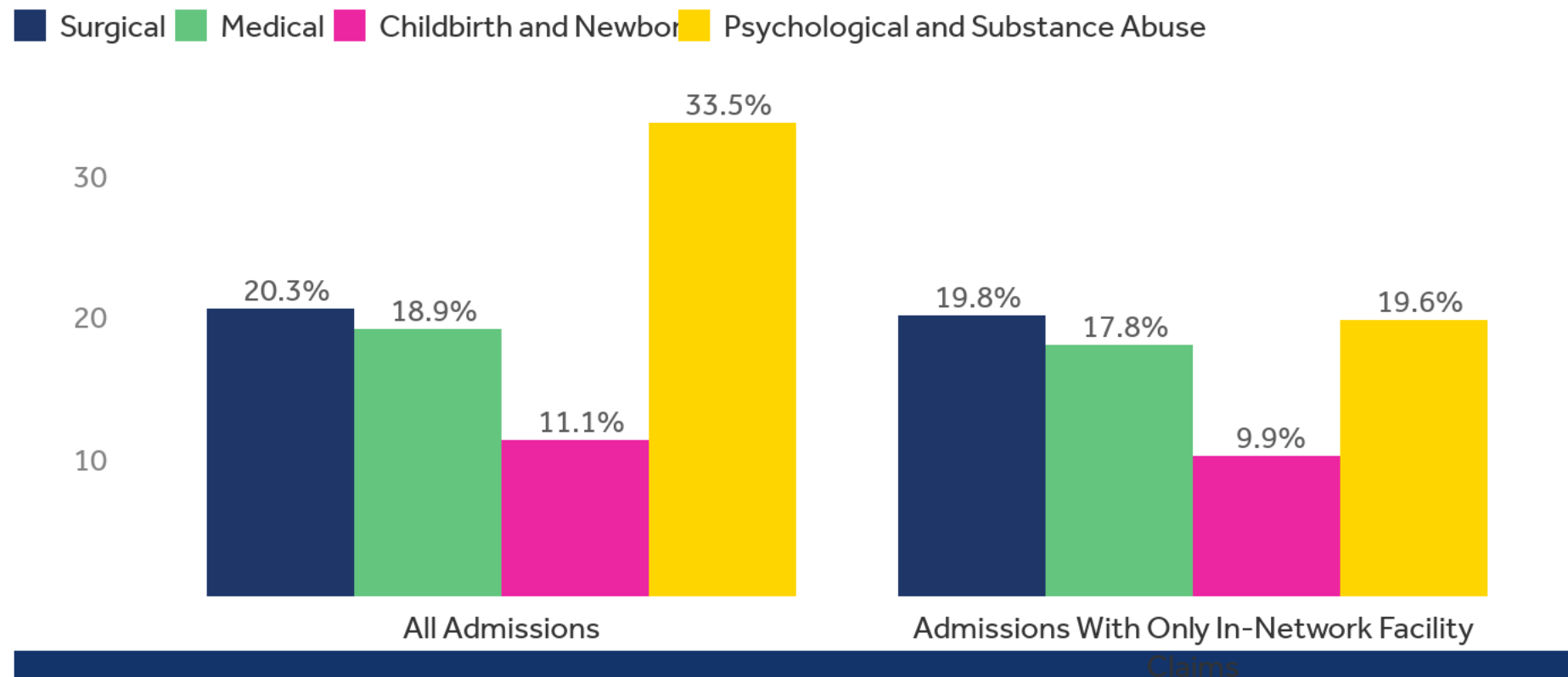
The Likelihood of Out-of-Network Claims

A 2016 Kaiser Family Foundation survey reveals the nature and likelihood of out-of-network provider claims

- Among people with employer-sponsored coverage, nearly 1 in 5 inpatient admissions includes a claim from an out-of-network provider
- Admissions that include an emergency room claim are likely to have a claim from an out-of-network provider, whether or not patients use an in-network facility
- Enrollees using outpatient mental health services are significantly more likely to have an out-of-network claim
- Enrollees with anesthesia or pathology claims are more likely to have an out-of-network provider claim, even when using in-network facilities
- <https://www.healthsystemtracker.org/brief/an-analysis-of-out-of-network-claims-in-large-employer-health-plans/>

Percent of Inpatient Admissions that Included an OON Provider Claim

Among people with large employer coverage, the percent of inpatient admissions that include a claim from a non-network provider, by reason for admission, 2016



Source: Kaiser Family Foundation analysis of Truven MarketScan data from large employer health plans, 2016

• [Get the data](#) • [PNG](#)

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Health System Tracker

How Will Surprise Bills Affect Your Plan?

1. What is your plan's percentage of out-of-network claims v in-network?
2. What methods do you use to control out-of-network claims and reduce your exposure?
3. How do you pay out-of-network claims – do you use an allowable charge formula or repricing service?



Major Health Benefits Trends

1. Continued cost shifting via higher copays or premium contributions
 - 108% increase in copays and deductibles since 2006 (wages increased 37%)
2. Annual per participant claim cost increase in Specialty Drugs (13% to 17%) and Hospital Claims (5%) driving much of plan cost increases
3. Greater emphasis on Rx prior authorization, step therapy, discharge coaches to lower readmission rates and other containment concepts
4. Narrow drug formularies
5. Narrow Hospital Networks
6. Increased Interest in Retail Clinics, On-Site Clinics, Telemedicine

Out-of-Network Claims as a Percentage of Total Plan Costs

Based on a sample of Segal Health Plan clients, out-of-network claims paid is a relatively small overall percentage of total paid claim dollars

- Out-of-network costs range from 5% to 15% of total plan costs
- Networks have done a better job of filling in gaps in provider networks
- Out-of-network out-of-pocket expenses have increased over time, resulting in a more engaged plan participant
- Nonetheless, surprise provider billing continues in emergency settings

Challenges Establishing Professional “Allowed Charge” Amounts

Insurers typically set their out-of-network (“OON”) allowed charge amount at:

- A **percentage of what they pay toward in-network providers** (easy because they have all the in-network pricing amounts), OR
- **At a percentage of what Medicare allows (e.g., 125% – 250%),** Medicare Professional Fee Schedules updated annually:
<https://www.cms.gov/apps/physician-fee-schedule/overview.aspx>

Challenges Establishing Professional “Allowed Charge” Amounts

But for self-funded, self-administered groups, OON repricing requires a database, research, and analysis

- Some self-funded Plans subcontract with **Bill Repricing Service Providers**
- Watch how these companies get paid for their services, typically as a “% of savings” (which can result in huge payments to these firms) with fees that can exceed the payment to the provider.
- Consider instead paying a % of the allowed charge, or pay PMPM if the plan has a good number of non-network claims each year.

Example: \$300,000 in lab fees OON, the repricing vendor keeps 35% of savings—vendor obtains a 38% discount, saves \$116,000, keeping \$41,000. No precertification and still cost Plan \$225,000 (\$184,000 + \$41,000) compared to a more reasonable allowed amount of \$5,000.

Challenges Establishing Facility “Allowed Charge” Amounts

- Other than Medicare, there is no commercially available database of hospital/facility “fair fees.” However, Fair Health has started to build this database.
- Hospitals use chargemasters: enormous pricelists containing every service, equipment, drug, or supply and the optimal price it seeks for each
- Effective January 2019, each hospital must post “standard charges” for all hospital inpatient and outpatient services online, even those not reimbursed by Medicare
- However, there is no definition of standard charges or guideline regarding format

Out-of-Network Facility Providers

With no easy access to an Allowed Charge database for facilities, plans can take these steps:

- Negotiate with the non-network facility for discount off billed charges
- Set a rate for reimbursement (per day or per procedure)
- Explore payment based on Medicare
- Determine whether secondary networks are available
- Explore options with stop loss carriers
- Audit, audit, audit

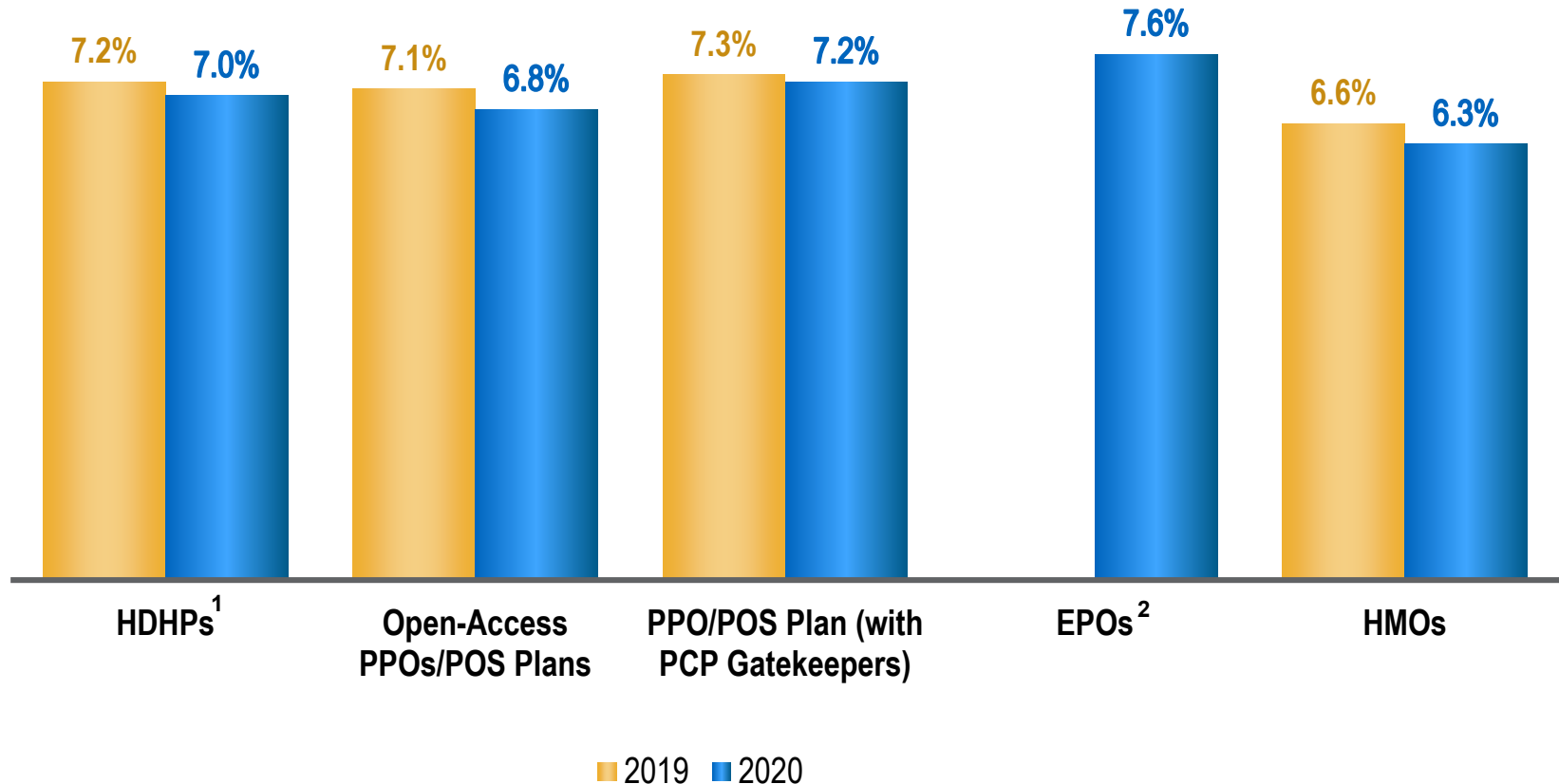
Mental Health and Substance Use Disorder Out-of-Network Claims

- Significant costs for out-of-network substance use disorder residential treatment
 - Increase in out-of-area services, especially in “vacation destination” states: California and Florida
 - Significant costs for out-of-network drug testing (due to frequency, scope and/or high per-test cost)
 - MHPAEA does not allow different controls for MH/SUD than medical

Mental Health/Substance Use Disorder Out-of-Network Claims

- Encourage participants to use in-network facilities
 - Push network providers to identify best facilities/providers (e.g., lower re-admission rates)
 - Performance guarantees for keeping patients at in-network facilities
- Communicate with participants about the value of using in-network facilities as a way to ensure quality and keep out-of-pocket costs low

Projected Medical Plan Cost Trends: 2019 and 2020



Source: 2020 Segal Health Plan Cost Trend Survey

¹ HDHPs with an employee-directed, tax-advantaged health account—a health savings account (HSA) or a health reimbursement account (HRA)—are referred to as account-based health plans and are designed to encourage consumer engagement, resulting in more efficient use of health care services.

² Segal began collecting EPO data as part of the 2020 survey, therefore, projected data is not available for 2019.

Ways to Minimize Non-Network Claims

- Promote a **customer service phone #** to find a network provider; some people are not adept at online provider searching but would call for help
- Consider **Plan design** changes that encourage greater network use
- Tighten network contracts to make them pay for renegade out-of-network provider bills when plan member did the right thing
- **Communicate to members**: frequent reminders on the patient's cost of going out-of-network, tips to avoid balance billing
- Add a **Referral process** so PCP can help members stay in the network through in-network referrals for care
- Require UM Company to check for non-network use during precertification, then **redirect to network providers** when possible
- Add a **health transparency tool** to help members more easily see the cost of routine services from network providers (versus what they could pay at retail, or out-of-network)

The Power of Member Communication

Illustrate to members the significant out-of-pocket liability when leaving the network for services

OUT OF NETWORK - NON-PPO

Physician Office Visit

Billed amount	\$300.00
Maximum allowable amount	\$150.00
Deductible - \$200.00 per person	\$150.00
Fund Payment - 80% after deductible	\$0
Patient Balance	\$300.00

Radiology (xray) & Lab

Billed amount	\$1,500.00
Maximum Allowable Amount	\$700.00
Fund Payment - 80% (no deductible)	\$560.00
Patient's Balance	\$940.00

IN NETWORK- PPO

Physician Office Visit

Billed Amount	\$300.00
Anthem Allowed Amount	\$150.00
Fund Payment	\$125.00
Co-pay Patient Balance	\$25.00

Radiology (xray) & Lab

Billed Amount	\$1,500.00
Anthem Allowed Amount	\$700.00
Fund Payment	\$700.00
Co-pay Patient Balance	\$0

Recap Potential Impact of Surprise Medical Bill



- Cost Impact to Plan depends on current plan design and non-network use
- Most proposals will hold patient harmless for balance billing
- Plan documents should be updated on how you define out-of-network reimbursement and allowable charges
- Ensure that service providers are monitoring and addressing any network gaps
- The bill, if enacted, could increase pressure for providers to join networks

Thank you!

Kathy Bakich
Washington, DC
202-833-6494

Ed Kaplan
New York, NY
212-251-5212

