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ASPS ISSUE BRIEF

Out of Network Billing

Balancing the Responsibilities of Insurers and Providers to Protect Patients

BACKGROUND

As the Affordable Care Act (ACA) has taken hold, two trends have emerged in the insurance marketplace that negatively impact providers and their patients –

(1) Health plans with narrowly-constructed provider networks are becoming commonplace in ACA health insurance exchanges and – to a lesser but still significant extent – in non-exchange markets.

(2) As a result of the first trend, more-and-more patients have had to go outside of the network of providers covered by their plan to see a needed specialist; been treated, without notification, by out-of-network providers at in-network facilities; or received emergency care from out-of-network providers.

Health plan networks are formed through a negotiation between insurers and health care providers who, in order to join the insurer's network, accept rates for their services that are usually deeply-discounted from the actual full charge. These fee agreements then prohibit participating providers from billing patients covered by the plan for the difference between the negotiated discounted charge and the full charge.

Because out-of-network providers have no such contractual obligation, though, patients can be responsible for the balance remaining on a bill after a claim is processed. Consequently, patients who receive services from out-of-network physicians are typically billed the portion of the physician's fee not covered by their health plan. Often, these costs are unexpected, which has resulted in this practice being termed "surprise billing".

COMMON SCENARIOS WHERE SURPRISE OR BALANCE BILLING OCCURS

Not all surprise billing situations are created equal, but there are several scenarios that are more likely to lead to a patient receiving a balance bill. The differences in these scenarios demand different approaches to determining reasonable rates and assigning financial responsibility.

SCENARIO 1: A PATIENT VOLUNTARILY GOES OUT OF THEIR NETWORK OF COVERED PROVIDERS

Occasionally, a health plan enrollee will choose to see a provider that they know is out-of-network, even when their plan has participating providers who are similarly credentialed and specialized. As subsequent sections of this document will detail, ASPS believes that all patients in this situation should, in advance of making such a choice, be fully informed of the responsibilities associated with going out-of-network to receive care. Assuming that information has been provided, enrollees should bear sole financial responsibility for covering a balance bill.

SCENARIO 2: A PATIENT VOLUNTARILY SEEKS CARE OUTSIDE OF AN INADEQUATE NETWORK

Sometimes, an individual needs to see a physician in a specialty or sub-specialty that is not covered by their health plan. At other times, the only in-network specialists a patient has access to would require the patient to travel an unreasonable distance or wait an unreasonable length of time to receive care. ASPS believes that patients should not be punished for the gaps in their insurer's product and that the plan should be responsible for paying the full cost of needed specialty care when it has failed to provide adequate alternatives.

SCENARIO 3: A PATIENT RECEIVES EMERGENCY CARE FROM OUT-OF-NETWORK PROVIDERS

After the stress of a medical emergency, patients should not be put into the middle of the billing process, and ASPS believes they should be held harmless when they have purchased health insurance. Patients in this situation who receive balance bills from out-of-network providers should be granted assignment rights, and payments to those providers should be determined based on a fair and balanced process between the provider and the payer. (ASPS's preferred approach to such a process is detailed later in this brief.)

The notion of balance is key, as a handful of states have enacted policies that too severely tip the scales in favor of insurance companies by preventing the option of balance billing and instead determining payments based on set fee schedules that disadvantage providers. Specifically, these fee schedules use the insurers' own claims data to determine the "usual and customary charge" for a particular service. Because this claims data is proprietary, such a system allows one party in a billing dispute – the insurance company – to control the data used to resolve the dispute.

When this approach is taken, insurers are able to hold reimbursements below appropriate levels by setting rates artificially low. Because emergency providers are required by federal law to treat any patient that enters the emergency department, setting provider rates at inappropriately low levels erodes the quality of emergency call care because it discourages specialists from taking emergency calls outside of their regular practice. The end result is a lack of access to critical specialists in emergency settings.

SCENARIO 4: A PATIENT RECEIVES OUT-OF-NETWORK CARE AT AN IN-NETWORK FACILITY

Surprise bills received under these circumstances draw some of the most intense ire, as they often come after a patient has made an effort to confirm that a facility or particular provider was part of their health plan's network. Unfortunately, the full team of providers who contribute to the entire continuum of services – direct or indirect – sometimes includes non-network participants. Because they are not subject to the same billing restrictions as participating providers, it is well within the rights of these non-network providers to balance bill patients.

While balance bills in this scenario cannot be eliminated entirely, their frequency, and more importantly incidence of surprise bills, can certainly be reduced. Ultimately, insurers, facilities and providers alike need to do more to achieve this goal.

POLICY RESPONSES

Combined with inaccurate network directories and caps on payments for medical care, the phenomenon of shrinking insurance networks has led to patients receiving large, unexpected bills at an unacceptable rate. In turn, this has led to growing scrutiny from legislators, regulators and the media.

Unfortunately, policy responses to surprise billing tend to focus too heavily on physician billing practices and not nearly enough on another significant part of the problem – insurance companies' selling inadequate products and failing to appropriately disclose the realities of the coverage their customers are purchasing. In doing so, policymakers give insurance regulators untoward power to set rates for physician fees. Simply put, the arc of the policy response to surprise bills is disturbing, as it radically skews the reimbursement system to place physicians at a disadvantage relative to insurance companies.

ASPS believes a system should be developed that protects patients and holds providers and insurers to the same high standards of disclosure, reasonableness and fairness. ASPS supports policy proposals that seek to address surprise billing by focusing on two core components:

(1) patients need to be fully informed that they might encounter out-of-network providers and held harmless when appropriate; and

(2) physicians need access to a system that allows them to be fairly compensated for their services.

INFORMING PATIENTS

The best way to eliminate surprise bills is to help patients understand the extent of their health coverage and their rights and responsibilities with respect to paying for out-of-network healthcare services. Each party that intersects with a patient's healthcare should be responsible for disclosing the network-related information about which it has knowledge.

- Insurer Disclosure Responsibilities - Because the insurance industry's drive to narrow networks is increasing the number of potential out-of-network providers a patient might see; ASPS believes that health insurers should take the lead in protecting their customers from surprise bills. This can be achieved by providing notice to its enrollees at critical junctions – upon issuance or renewal, as part of any explanation of benefits, and upon receiving a request or pre-certification for a healthcare service or supply.

  Such a notice, when given at issuance or renewal of a policy, should include:
    - a clear disclosure that an enrollee may receive care at a covered facility from a provider who is
        - not included in the plan's provider network and
        - who may balance bill the enrollee for amounts not paid by the health benefit plan.
    - a list of all healthcare facility-based providers who participate in the plan's provider network. These lists should be delineated by facility and sub-delineated by specialty.

  Such a notice, when given in an explanation of benefits, should include:
    - a separate, readily identifiable and plain language list of all payments made to non-network physicians.
    - a plain language note that the amount paid to such providers may not cover the provider's entire fee.
    - a clear statement that the enrollee may be billed for the remaining balance.
    - information about the enrollee's right to assign future balance bills.

  Additionally, when a health plan receives a request for pre-certification of a healthcare service or supply, notice should be given to their enrollee that includes:
    - a clear disclosure of whether the provider requesting pre-certification is a part of the enrollee's covered network.
    - all enrollee payment responsibilities, including an estimate of potential balance bill amounts based on coinsurance and the insurer's usual and customary out-of-network payment rate for the services requested.

- Healthcare Facility Disclosure Requirements – Facilities also have an obligation to ensure that their patients are fully informed of the potential for interactions with out-of-network providers. The process of sharing this information should be structured to give patients an opportunity to make adjustments to avoid balance bills. To accomplish this, facilities should provide written notice to a patient at pre-admission or at the first non-emergency encounter at the facility, that:
    - clearly states whether or not the facility is, or is likely to be, in-network on the date upon which services will be delivered.
    - clearly states that the patient may receive services from an out-of-network provider and receive a bill from out-of-network providers for the cost of those providers' services in excess of the amount covered by the patient's health plan.
    - provides the full name, professional designation and – if applicable – specialty area, for each facility-based provider or facility-based provider group with medical staff privileges at the facility.
    - lists the insurance plans with which the facility participates, and specifically denotes any employed providers or contracted physician groups that do not participate in those plans.

- Facility-Based Provider Disclosure Requirements – ASPS believes that facility-based providers also have a role in addressing this problem. They can take steps to reduce their patients' potential exposure to out-of-network costs, reduce instances of surprise billing, and reduce the confusion patients feel when they actually do receive a balance bill. To accomplish this, facility-based physicians should:
    - provide to the patient a list of any other providers that the physician knows, at the time of scheduling a facility-based service with a patient, will participate in the service.
    - provide to the patient, at the time of scheduling a facility-based service with a patient, notice that –
        - it is the patient's responsibility to determine if listed additional providers are participants in the patient's health plan network.
        - additional out-of-network providers may subsequently be scheduled to participate in the services.
    - explain, when balance billing a patient as an out-of-network provider, that –
        - the physician is not covered by the patient's health plan.
        - the patient's health plan has paid a rate below the physician's billed amount.
        - offers remedies available to the patient, including alternative payment agreements and options for assignment.

FAIR PAYMENT

When mechanisms are in place that allow for fair provider compensation, payers are incentivized to set their rates at reasonable levels. When physicians receive reasonable payments for their services, they are less likely to balance bill. When balance bills *are* necessary, the best system is one that uses independent data sources to establish fair and reasonable rates. ASPS believes any such system must:

- Retain a balance billing option. This should only be allowed following full disclosure, acknowledged in writing by a patient, of a potential out-of-network provider interaction prior to such an interaction occurring.

- Allow a patient who receives a surprise bill for out-of-network services, provided in an emergency or at an in-network facility, to retroactively assign benefits to the provider, pay only their cost sharing obligation, and apply that cost sharing toward their annual out-of-pocket limit for in-network services.

- resolves billing disputes based on data from a third party claims database administered by a non-governmental, not-for-profit entity.

Too often, though, existing and proposed systems for determining, reviewing and adjusting out-of-network payments skew heavily in favor of payers at the expense of doctors and patients. The most common manifestation of this is in imposing a fee schedule based on one of three flawed methodologies: (1) a health plan's rates for in-network services; (2) a percentage of a plan's usual and customary rates for out-of-network services; or (3) on a percentage of Medicare's payments for services. Each of these approaches is problematic in its own way.

Specifically, when payments for out-of-network services are based on in-network rates, physicians are essentially forced to be network participants without the benefits or protections that come through the process of actually contracting with a health plan; when out-of-network payments are based on a plan's usual and customary rates for services, plans are able to artificially suppress payment levels because the data insurers use to come to a "usual and customary" rate is proprietary; and lastly, Medicare rates are notoriously insufficient.

As an alternative to these flawed approaches, fee schedules are better when developed using unbiased healthcare claims data, such as that provided by FAIR Health, Inc. FAIR Health is an independent not-for-profit that provides an objective window into healthcare cost information to all interested stakeholders. FAIR Health has the nation's largest collection of privately billed medial

claims data. Its healthcare cost information is organized geographically, so it can be utilized to provide relevant cost information that is regionally specific. FAIR Health also provides fee estimator services to providers and free treatment cost estimates to consumers.

When mechanisms are in place that provide transparency on fair provider reimbursement for out-of-network services, payers are incentivized to set their rates at reasonable levels. When physicians receive reasonable payments for their services, they are less likely to balance bill.