HMA Inspire Webinars

What You Need to Know

About Balanced Billing

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November 19, 2019

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What we will cover

- Issues around balance billing
- Evolution of current surprise billing legislative policy
- Overview of state, federal policy proposals
- Pending surprise billing legislation, impacts on providers, patients, employers and payers
- What does it means for health plans, design strategies for 2020 and beyond

Understanding Balance Billing

Balance Billing occurs when charges for care exceed the benefits available to a patient under their insurance coverage for care received from a provider or facility that is not “in-network”

Out-of-Network care is either:

“Elective” –
patient choice is exercised

“Surprise” –
patient is not aware, and caused by Seeing a OON provider at an in-network facility Due to emergent care

Factors Contributing to Balance Billing

Costs

- Rising cost of healthcare (billed charges)
- Increasing plan expenditures
- Adoption of cost containment strategies

Network Management

- PPO & narrow-network contracting strategies (limiting access)
- Centers of Excellence/quality focus
- Providers intentionally not contracting
- Limited nationwide network offerings that are affordable

Provider Outsourcing

- Facilities are increasing contracting with provider groups for ER, hospitalist, radiology, labs, etc. services who contract and bill independent of the facility
- Lack of patient choice & transparency prior to care

Factors Contributing to Balance Billing

Evolution of Consumerism Philosophy

- Higher patient “skin-in-the-game” financial responsibility (cost sharing) for care
- Reduced benefits for out-of-network coverage/steerage to in-network care options
- Technology advancements enable transparency for patients to make care decisions, provider selections
- Rise of consumer oriented plan offerings vs. traditional PPO/HMO options

Financial Realities

- Growing medical debit, financial hardship
- Widening gap between what providers are willing to accept for payment, and what health plans are willing to pay

  2016 Fed. Rev. study found 44% of U.S. households cannot pay an emergency expense of $400 or more without borrowing or selling possessions

Early Efforts to Curb Balance Billing

ACA- Transparency efforts

- The Affordable Care Act Section 2715A (9/23/10), Section 1311(e) (1/1/14) of ACA sought to glean data through mandatory reporting by plans on OON costs to enrollees, but the provision has not yet been implemented

NAIC – Access & Adequacy standards

- Fall 2015 – NAIC updated network access and adequacy model act to address surprise medical bills

Going Where the ACA Didn't Go

- ACA (in part) was an attempt to control the **cost** of healthcare and **protect** patients from financial exposure
- Legislative efforts since 2015 to address balance billing 'surprises' thematically are geared to **protect** patients from financial exposure, and to attempt to control the **cost** of healthcare
- Limited data exists on the incidence and impact of balance billing

Data Tells the Story

- **Feb 2011** - an internet panel survey found 8% of respondents used an OON provider; 40% was involuntary OON care; 68% due to medical emergencies

- **2011** - NY Dept. of Financial Services looked at over 2,000 complaints involving surprise medical bills; 90% were for ancillary inpatient care (anesthesiology, lab, surgery, radiology)

- **2013** - private study of data collected by Texas DOI suggested that between 41% - 68% of billed charges for emergency physician care was submitted by OON providers, for care performed in a contracted facility

Data Tells the Story

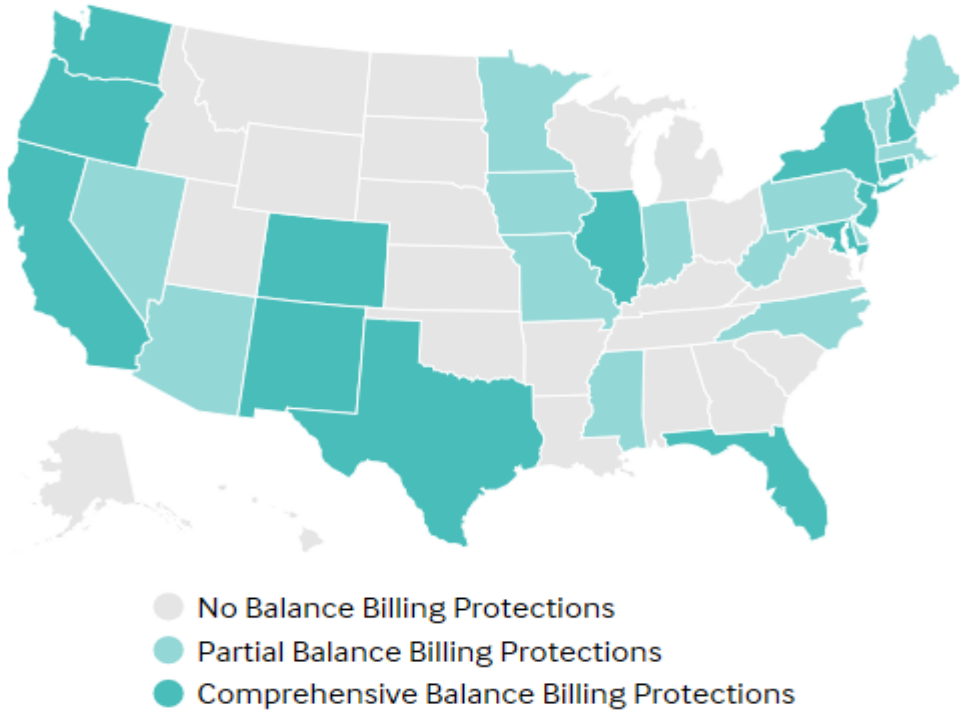
- **Aug/Sept 2015** - KFF and The New York Times survey - 26% of respondents report they or someone in their household had problems paying or an inability to pay medical bills in the previous 12 months; 66% involve one-time or short term care

- **2016** - Nearly 1 in 5 inpatient admissions includes a claim from an OON provider based on Truven MarketScan data

- **2016** - KFF survey of medical debt found that among individuals who faced OON bills they could not afford to pay, nearly 7 in 10 did not know the provider was OON at the time they received care

Legislative Recap

- State efforts 2015-2019



Source: M. Kona, et al, Center on Health Insurance Reforms, Health Policy Institute, Georgetown University.

Trends

- Payers must hold harmless patients above in-network level of cost sharing.
- Providers cannot balance bill for amounts above in-network level of cost sharing.
- Care covered by protections: ER & in some states non-emergent care @ in-network facilities.
- Use of negotiation/arbitration dispute resolution is common.
- Medicare, percentile of billed charges, or claim data from payer databases maintained by the state for ‘reasonable rate’ benchmarks.

State Developments – Closer to Home

Oregon's law (HB 2339) took effect on March 1, 2018

- Prohibits balance billing on emergency & non-emergent services @ in-network facilities
- State uses data from the APCD to set a 'reasonable' payment standard

Washington's law (HB 1065) takes effect on January 1, 2020

- Addresses Emergency Room and certain ancillary services @ in-network facilities
- Data from APCD that WA is trying to make accessible for use
- Extends to care received in border states. Discusses possible inter-state agreement for continuity
- Creates an "opt-in" offer for Self-funded health plans

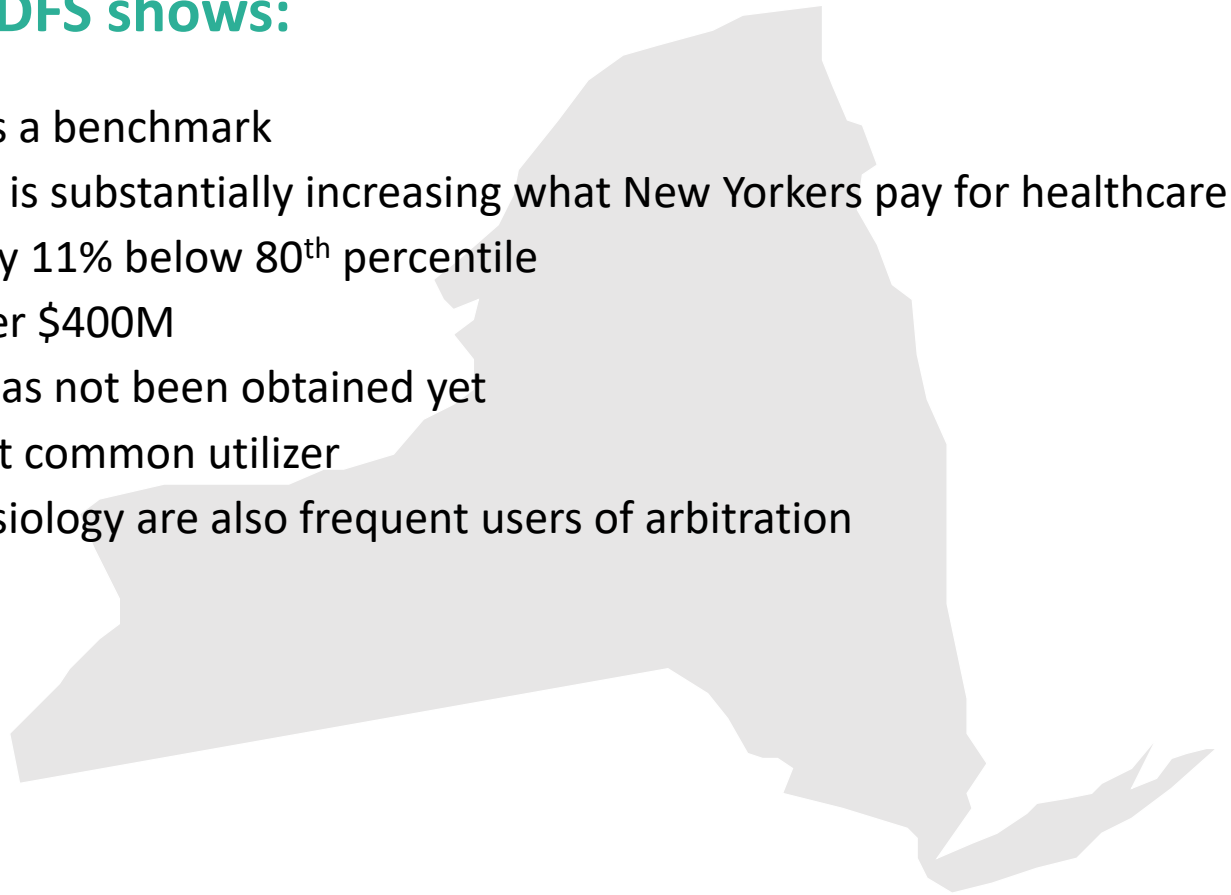
California's law (AB 72) took effect on July 1, 2017.

- Prohibits balance billing on emergency & non-emergent services @in-network facilities
- Only applies to plans regulated by CA Dept. of Managed Care, which includes HMOs and PPOs
- Reimbursement for Emergency Care must be a reasonable & customary value for the care. For non-emergent care @ in-network facilities, must reimburse the greater of 125% of Medicare, or the average contracted rate for that Plan and region

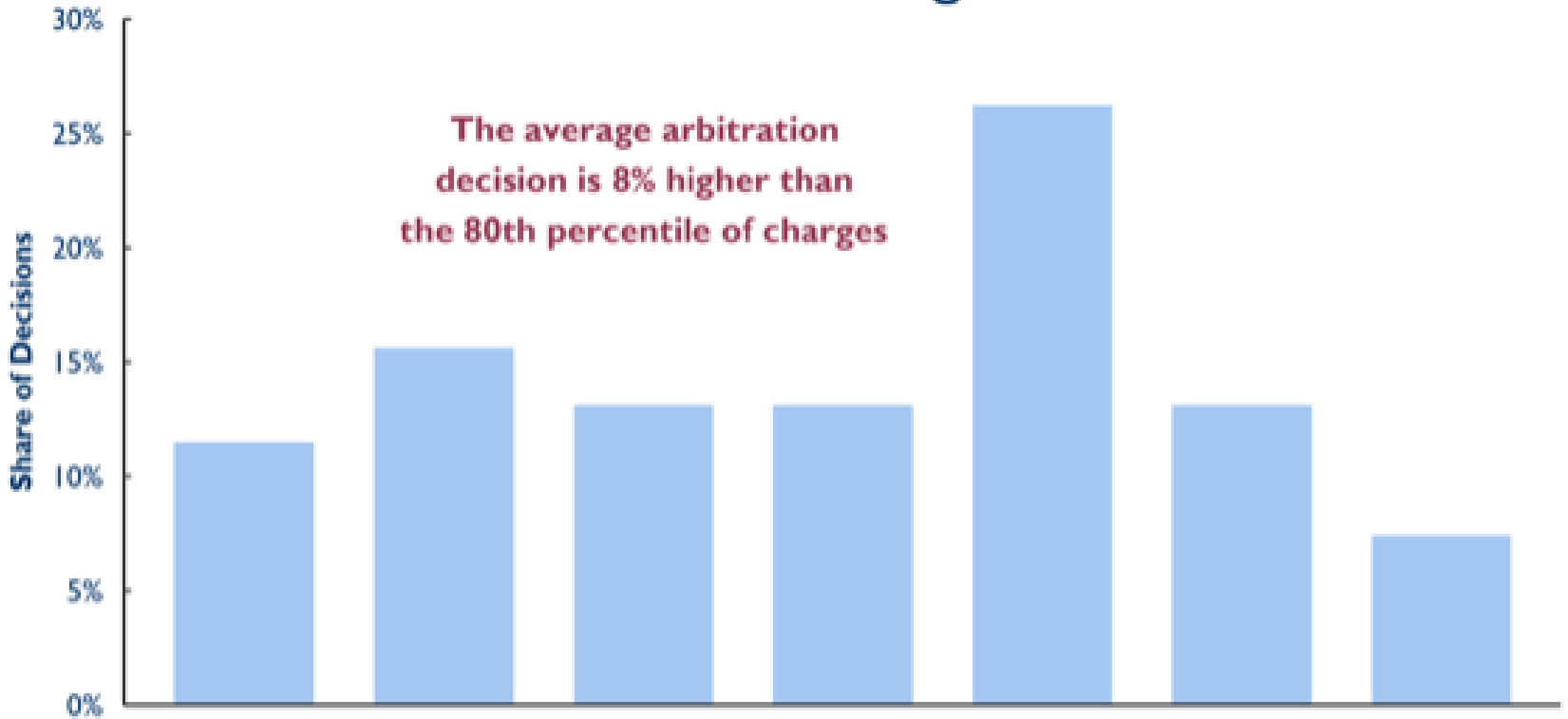
NY Learnings – Success?

Recent study released by NY DFS shows:

- Arbitrators use 80th percentile as a benchmark
- Data suggest arbitration process is substantially increasing what New Yorkers pay for healthcare
- Health plan “wins” averaged only 11% below 80th percentile
- The report estimates savings over $400M
- Data suggests that equilibrium has not been obtained yet
- Plastic Surgeons in the ER – most common utilizer
- Emergency Medicine & anesthesiology are also frequent users of arbitration



Arbitration Decisions Relative to 80th Percentile of Charges in New York



Average Difference from 80th Percentile of Charges	50-100% Lower	20-50% Lower	0-20% Lower	80th Percentile of Charges	0-20% Higher	20-50% Higher	>50% Higher
	-75.4%	-36.5%	-8.5%	0.0%	7.4%	30.4%	235.9%

Note: The New York Department of Financial Services estimated this distribution by examining a random sample of 181 decisions between 2016 and 2018.
Source: New York Department of Financial Services

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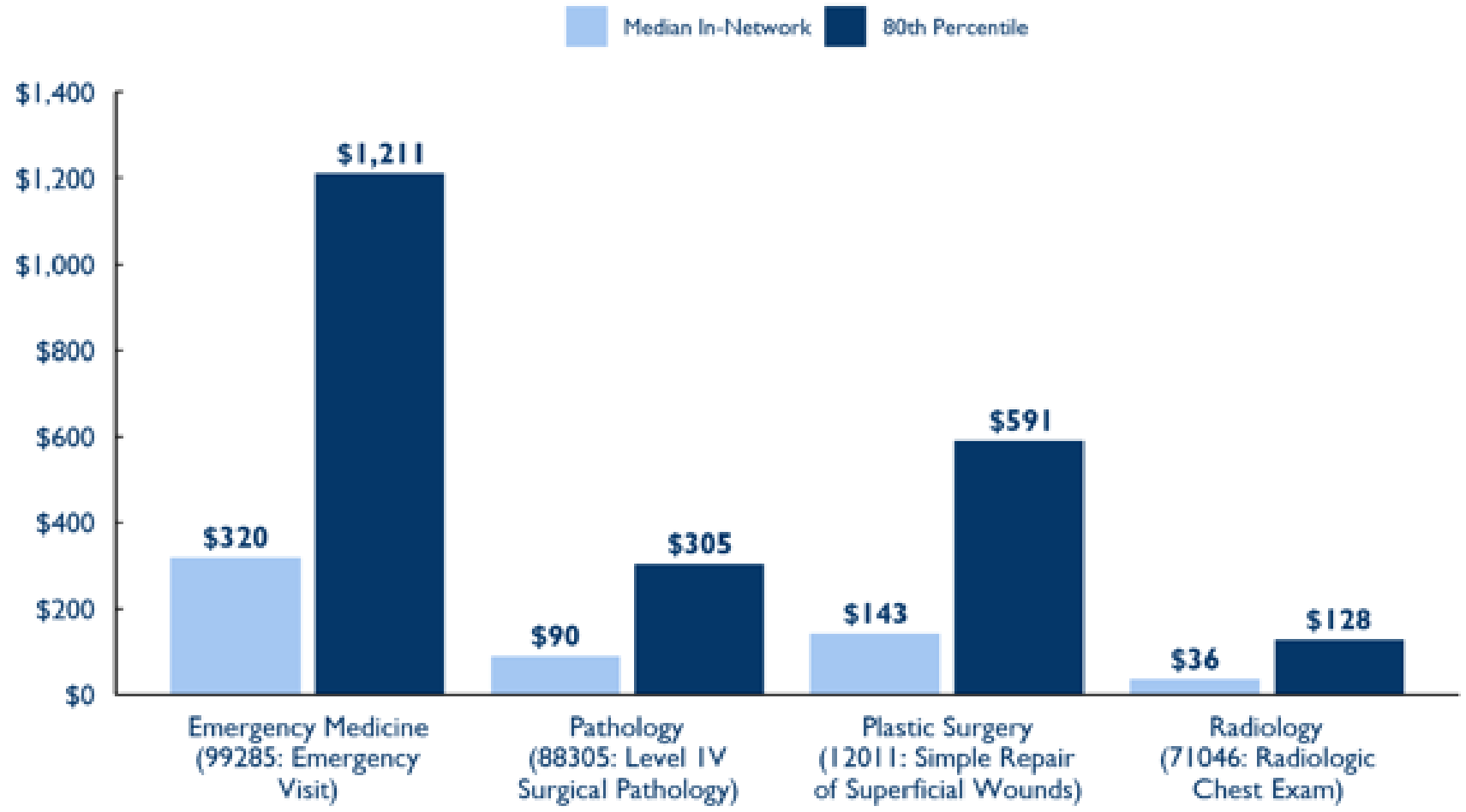
New York: 80th Percentile of Charges vs. Median In-Network Rates (2018-19)



Source: FAIR Health

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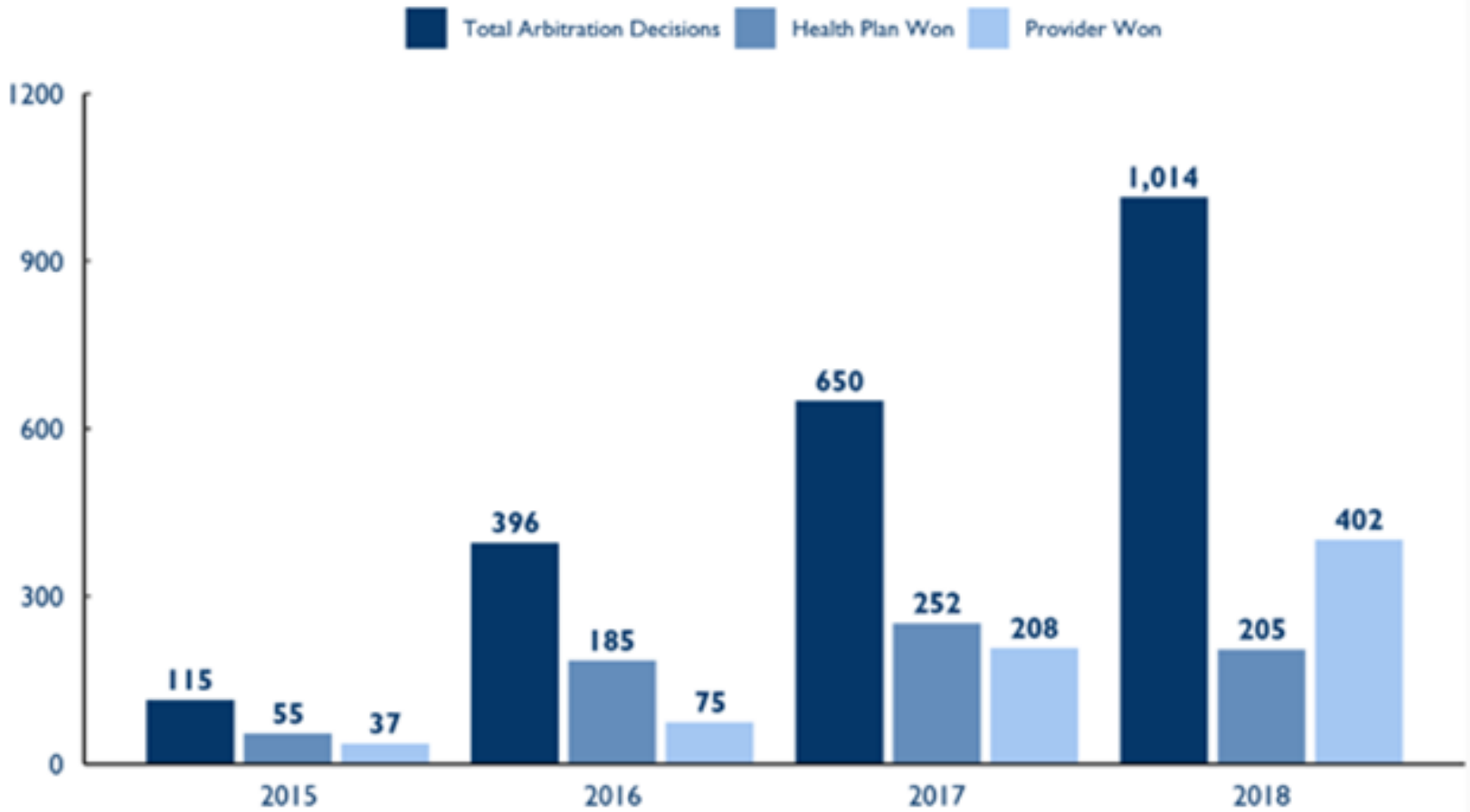
Breakdown of NY Arbitration Decisions



Note: "Total Arbitration Decisions" represents the total number of eligible bills for which a decision was rendered. Decisions won by either the health plan or provider do not sum to the total number of decisions because the remainder are split decisions when multiple services were being adjudicated.
Source: New York Department of Financial Services.

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Limitations of State Solutions

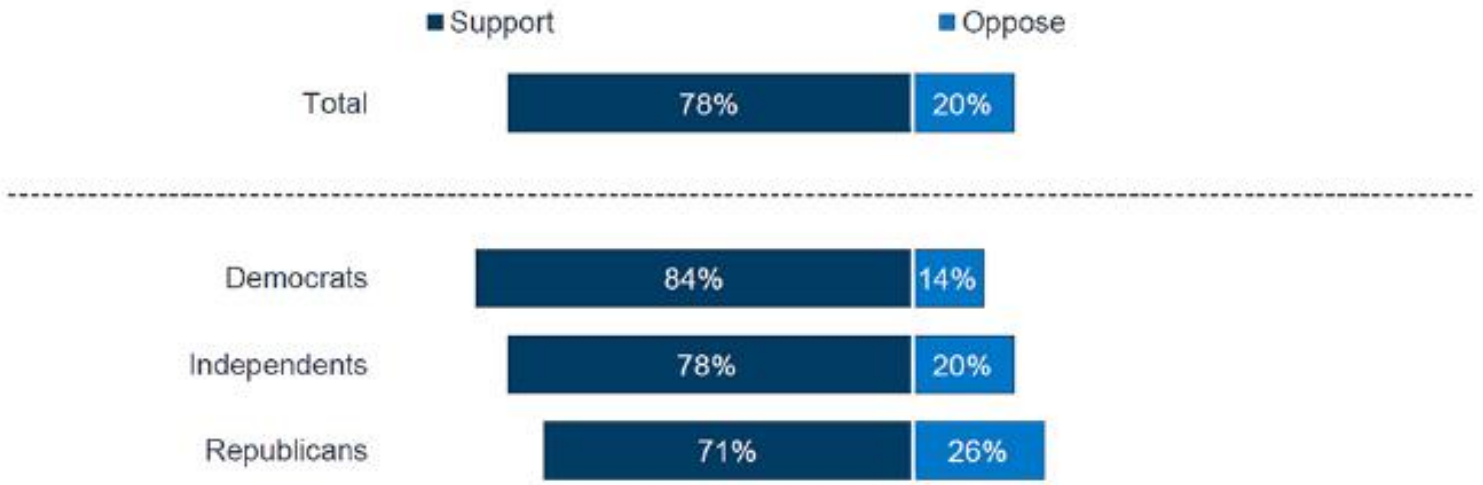
- Many states are requiring transparency disclosures by payers, providers
- Elective decisions to go out-of-network are not covered by protections
- Patchwork solution – with variability between scope of coverage; many would not be considered “comprehensive protections”
- States cannot regulate self-funded ERISA plans
- States cannot regulate air ambulance charges/balance billing practices
- No state based efforts yet on ground ambulance charges

Strong Bipartisan Support

Surprise Medical Billing

Majorities Across Partisans Support Surprise Medical Bill Legislation

Do you support or oppose legislation protecting patients from paying the cost not covered by their insurance when they receive care from a provider or hospital who is not in their network?



SOURCE: KFF Health Tracking Poll (conducted September 3-8, 2019). See topline for full question wording and response options.

KFF

Federal Legislative Efforts

115th Congress

- Protecting Patients from Surprise Medical Bills Act – *Senator Cassidy (R-LA)*
- No More Surprise Medical Bills Act of 2018 – *Sen. Hassan (D-NH)*
- End Surprise Billing Act of 2017 – *Rep. Lloyd (D-TX)*
- Fair Billing Act of 2017 – *Rep. Grisham (D- NM)*

116th Congress

- S. 1895 Lower Health Care Costs Act – *Sens. Alexander (R-TN) & Murray (D-WA)* – Passed HELP committee
- H.R. 3630 No Surprises Act– *Reps. Pallone (D-NJ) & Walden (R-OR)*- Passed E&C Committee
- S. 1531 – *Sens. Cassidy (R-LA) & Hassan (D- NH)*
- H.R. 3502 – *Reps Ruiz (D-CA) & Roe (R-TN)*
- H.R. 861 – *Rep. Doggett (D-TX)*
- S.1266 – *Sen. Scott (R-FL)*

Taking a Closer Look

Lower Health Care Costs Act

- **Enforcement** – state w/federal fallback; civil monetary penalties
- **Payment standard** – median in-network rate for payer
- **Hold harmless standard** – in-network cost sharing amounts
- **Setting** – ER & post stabilization care & non-emergent in in-network facilities; applies to FI &SF; includes air ambulance services
- Defers to state payment standards for state-regulated plans
- No dispute resolution process

Taking a Closer Look

No Surprises Act

- **Enforcement** – state w/federal fallback; civil monetary penalties
- **Payment standard** – median in-network rate for 1st year, inflated for future years
- **Hold harmless standard** – in-network cost sharing
- **Setting** – ER & post stabilization care & non-emergent in in-network facilities. Applies to FI &SF. Requires itemization for certain air ambulance bills
- Defers to state payment standard for state regulated plans, but patient coinsurance is based on lesser of state or federal payment standard
- Binding arbitration for cases over $1,250 with other restrictions; does not allow billed charges to be considered

Impacts of Physician Staffing Organizations

For the past 8 years –Emergency Medicine & Anesthesia fields increasingly see investors taking over and operating large Doctor staffing & billing companies backed by hedge funds.

EmCare

- Owned by KKR
- OON billing rates go up between **81-90 percentage points**
- Physician rates increase by **117%**
- Billing trends also see increases in imaging & admission rates, and ER visits are **43% more likely** to bill for ER care using the highest paying & highest acuity billing code

TeamHealth

- Owned by Blackstone
- OON billing rates increase by **33 percentage points**
- Physician rates increase by **68%**
- **30%** increase in # of cases treated per year in the Emergency Department

Lobbying Efforts

Physician groups, investors in private equity and venture capital firms continue to mount strong opposition campaigns

A Different Approach?

What if the focus was on the underlying contract versus price?

- Bundled approach as patients are choosing a bundle of services which includes both hospital and physician
- State would require hospitals to sell and networks/plans to contract for an ED service bundle; including both facilities and physician services

Yale study: https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling_isps17-22.pdf

A Different Approach?

Competitive Negotiations

- Hospitals pay fair rates to physicians for local labor
- Physicians compete on price & quality to obtain privileges to practice at hospitals
- Hospitals and networks maintain competitive contracts for ED services
- Hospitals compete on price & quality to attract patients and be included in networks
- Networks & plans compete over premiums & breath of networks to attract/retain customers.

The policy can be applied uniformly as it is a not an attempt to regulate insurance, but rather a form of hospital regulation, so it applies to all patients. Could be adopted federally, where ED bundles would be a requirement for Medicare payments.

Yale study: https://isps.yale.edu/sites/default/files/publication/2017/07/surpriseoutofnetwrokbilling_isps17-22.pdf

Plan Design & Administration Impacts

Things to think about

- Who pays arbitration and negotiation costs?
  $8-$10k each

- *For payers* – strategic investments in tools and systems to provide transparency and cost estimator/pre-determination type disclosures on demand

- *For providers* – no more secret chargemasters

- Rural areas – lack of competition or incentive to contract for physicians.
  How to address?

- Increased pressure to define exactly what will be paid for care for out-of-network.
  What methodology is being used?

Plan Design & Administration Impacts

Plan designs

- OON benefit strategies

  Reference based models? Percentiles of UCR? Or?

- Monitor mental health and ambulance benefits – as these tend to be areas where OON use is common and billed charges high and network adequacy concerns tend to be raised

  How do you think about plan design coverage if in-network options are limited?

- If self-funded, does adhering to the rules that fully insured plan comport to make sense? Or is there a competitive advantage to not aligning?

- Employer philosophy around coverage for OON care

What comes next?

Ground ambulance lobbying efforts for similar legislation and protections

Current admin is pushing transparency requirements as part of the Executive Order issued earlier in 2019

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Q + A

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Monday Dec. 9th
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