



**Out-of-Network Billing:  
Finding a Message That Works**  
AMA State Legislative Strategy Conference 2016  
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# Overview

- Challenges
- Initial & Current Thoughts
- Current State of Affairs
- Current Actions
- Next Steps
- Near Future Possibilities

# Challenges

- Patients do not have a choice of physician (in or out of network) when seeking care in the ED
- Physicians do not have a choice in terms of caring for those patients – EMTALA
- Insurers have been effective in portraying physicians as “the problem” and making themselves seem patient allies.
- Regulators do not care about physician reimbursement as long as there is “adequate access” (which is guaranteed by law)

# Initial Thoughts

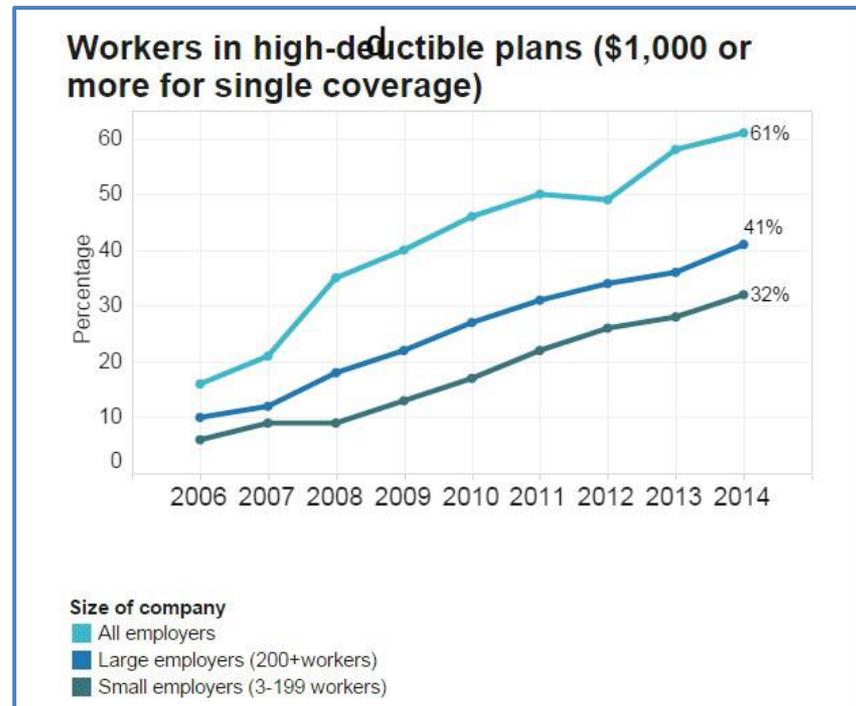
- Do not talk about “balance billing” – doesn’t work in discussion.
- Talk about “fair payment” for physicians
- Understanding the ACA law and the “Greatest of Three” rule, work with CCIIO to clarify the interim final rule regarding the need for transparency of the UCR
- Work with NCOIL and NAIC to ensure fairness in what is promulgated as examples

# Current Thoughts

- No longer talking about “Fair Payment”
- Talking about “Fair Coverage” for Patients
- Need to be active about striking back portraying insurance companies as the demons
- Insurers have hoodwinked patients by offering them “affordable” premiums while not being forthright about coverage (as was said yesterday, “The first and only thing patients look at is the premium.”)

# Current Thoughts

- Promote our position as patient advocates
- Point out the rate of rise of high deductible insurance plans
- Average deductible \$1318
- Average liquid reserves <\$700



# Current Thoughts

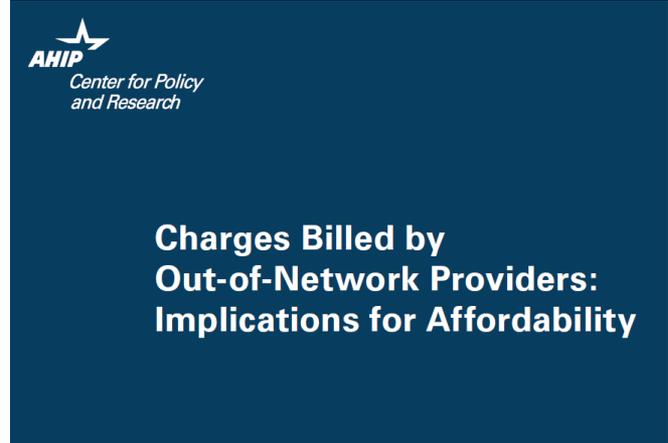
- Too often what patients perceive as “surprise bills” are actually their deductibles.
- We want the patients out of the middle of the war between insurers and physicians.
- We want insurers to offer “fair coverage” for patients and “fair payment” for physicians.
- If we want there to be transparency in what insurers pay, we may have to be transparent in terms of what our members charge.

# Current State of Affairs

- OON BB varies state to state
- Banned in some states – CA
- Recent passage of laws in several states – NY, CT, IL, TX
- Legislation defeated in several states
- Not an issue in other states – LA
- Clearly will be brought up in many states in 2016

# Current State of Affairs

- AHIP report on Surprise bills
- NAIC model legislation
- Recent final rule on interpretation of the “Greatest of Three” by CCIIO → significant change from interim to final in the wording from “charges” to “amounts”



# State Laws - Connecticut

- The carrier must reimburse the provider the greatest of 1) the amount that would have been paid to an in network provider; 2) the UCR amount; or 3) the Medicare reimbursement amount.
- UCR is defined as “the 80<sup>th</sup> percentile of all charges for the particular health care service performed by a health care provider in the same or similar specialty and provided in the same geographical area, as reported in a benchmarking database maintained by a nonprofit organization specified by the Insurance Commissioner. Such organization shall not be affiliated with any health carrier.”
- Fair Health is the only database known currently to meet the requirements stated in the definition.

# State Law – New York

- Legislation passed in 2014 created an independent review process designed to protect patients from “surprise” out of network bills. The process created under the law has been dubbed “baseball arbitration” because 1) it required the arbitrator to choose the reimbursement amount submitted by one of the sides (meaning that the arbitrator could not choose an amount between the submitted figures); and 2) the loser is required to pay for the arbitration.
- NY ACEP was successful in getting emergency services (based on CPT codes) to be excluded from the requirements of the bill if the billed amount is under \$600 and less than 120% of the UCR amount for the specific CPT code, with usual and customary being defined as the 80<sup>th</sup> percentile of an independent database.

# State Law - Illinois

- Under most circumstances a nonparticipating facility based provider is prohibited from balance billing the patient (except for applicable deductibles, copays, etc.). The law does not specify a mechanism for determining adequate reimbursement if the insurer determines to pay less than the billed amount, in which case the provider and insurer are supposed to negotiate reimbursement. If they cannot do so, then one of the parties may initiate a nonbinding arbitration process.
- The binding arbitration process is not appropriate for the amounts typically in dispute (IL ACEP), with the result that emergency physicians do not utilize the process, and underpayment is a frequent, ongoing problem.

# State Law - Texas

- For several years, Texas has had a dispute resolution process that could be utilized by enrollees who received a balance bill for an amount greater than \$1,000. Because of that amount, the process did not frequently impact emergency medicine. However, in 2015, legislation reduced the threshold to \$500, which puts it at a level more likely to impact emergency services.

# State Law - Texas

- Insured enrollees receiving a balance bill for more than the threshold amount can submit a request for arbitration. Once the person does so, health care providers are prohibited from seeking payment from him/her until the dispute resolution process is concluded. By requiring the enrollee to file the dispute resolution request, the law ensures that the patient remains involved in the process. In practical terms, the result of this is that insurers have felt compelled to resolve the disputes, with the result that nearly all disputes have been resolved before actually going to the arbitrator.

“All we asked for at every one of our meetings with CCIIO was an objective standard by which benefits for OON emergency care services would be transparently determined, enforceable, reasonable, and market driven. Our proposal would have also addressed those charges by providers that were excessive,

an “We would respectfully suggest that a payment scheme that additionally results in inadequate payment for insured patients and disincentivizes insurers from fair negotiations endangers this safety net.”

physicians and the company was fined \$300 million. Those funds were used to set up an open, non-profit database for charge data (Fair Health). Unfortunately, this final rule basically re-creates the same environment for insurers to use black box methods to determine physician payment.”

# Current Actions

- 3 Task Forces in the reimbursement arena
  - OON Balance Billing
  - Medicaid Access
  - Alternative Payment Models
- ACEP Reimbursement Committee subcommittee also actively working on OON/BB
- Several organizations combining efforts – ACEP, EDPMA, EMAF
- ACEP President-elect chairing a special work-group of leaders of all efforts

# Next Steps

- Work-Group strategies
  1. Survey our chapters where there has been a ban on balance billing to ask how it has affected their practice and reimbursement.
  2. Survey our chapters that have been successful in defeating attempts to limit BB – e.g., Louisiana, Texas – and ask them what worked, what strategies are best, pitfalls to avoid.
  3. Produce a resource for our chapters that might be something like “5 Things to Consider” or “Best Practices” when dealing with this issue → A Toolbox.

# Near Future Possibilities

- Letter to CClHO: “In light of the EMTALA obligation to provide emergency care regardless of payment, these Final Regulations, by allowing plans to unilaterally determine the reasonable value of these services, encourage an *unconstitutional taking* of physician and hospital services.”
- Consideration of legal action against CClHO.

# For more information

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