**Guiding Principles and Annotations Document for Out of Network (OON) Legislation from the ACEP/EDPMA Joint Task Force on Reimbursement Issues (JTF) (hereinafter “2017 Guiding Principles” to distinguish it from the 2016 JTF Strategies White Paper previously approved by both ACEP and EDPMA boards of directors, respectively)**

**This document serves as a supplement to the OON model legislation (OONML) document, providing explanatory notes and strategic guidance. Annotations are indexed to the appropriate section of the model legislation document.**

**Premises and Guiding Principles:**

* 1. By “Model Legislation” we mean optimum legislation. Stakeholders at the state level may have to compromise on various issues. The American College of Emergency Physicians (ACEP)/Emergency Department Practice Management Association (EDPMA) Joint Task Force (JTF) understands that deference to these state level stakeholders is required in these areas. Also, given the agreement by national specialty societies representing anesthesia, radiology, orthopedic surgery, plastic surgery and hospital medicine on common principles and proposed solutions, the OONML attempts to apply the minimum benefit standard (MBS as defined in D below) to hospital based specialties as the JTF believes the joint multi-specialty approach is the best approach. The JTF understands, however, that once the legislative process is underway, specific specialties may be addressed and others not addressed in proposed bills.
  2. ACEP/EDPMA believes strongly that the issues must be framed to indicate that Insurance Carriers are narrowing networks, the vast majority of patients do not understand their insurance coverage, and with the high deductible plans of today that patients are essentially self-insured outside of a major hospitalization or an extensive procedure.
  3. Insurance Carriers should be required to waive deductibles for non-elective care.
  4. In that Fair Health is a widely recognized independent and verified database of over 20 Billion claims, the Fair Health 80th percentile\* standard should be the Minimum Benefit Standard (MBS) under the law as it is both transparent to all stakeholders and removes the Patient from potential reimbursement disputes between the Clinicians and Insurance Carriers. Fair Health was also cited in comparison to all other known alternatives as the most comprehensive and transparent benchmark for OON reimbursements by the University of Chicago’s 2014 report (NORC report), when CMS requested the University to analyze potential databases, both commercial and non-profit: “[F]air Health is the database best suited to help address CMS’ concerns about establishing comprehensive and transparent out of network payment benchmarks.” Consideration may be given to geographic variability in those states that have disparate Fair Health 80th percentile values. Consideration may be given to setting a benchmark date for determination of the minimal benefit standard. Consideration may be given to setting a benchmark for COLA increases to the MBS
  5. The Insurance Carrier cannot solely initiate mediation.

**Annotations**

**Annotations for l c**: Also sometimes referred to as the Clinician’s Actual Charge. Note: avoid the terms “usual, customary and reasonable charges or amounts”: also known as the “UCR”, this concepts dates back to when Medicare reimbursed physicians (in the pre-physician fee schedule days, e.g. pre-1992) on a percentage of their UCR. Insurance Carriers prefer to include the word “reasonable” to the “usual and customary” term to permit them to determine, in their sole discretion, if the charges are reasonable or not. As was stated recently in the Center for Consumer Information and Insurance Oversight (CCIIO) explanation for the final rule on payment for out-of-network emergency services, the Insurance Carriers would like to move the definitions away from “usual and customary charges” to “usual and customary amounts”. By shifting the focus away from what Clinicians charge to all Patients and payers regardless of Insurance Carrier or status—their “usual” and “customary” charges—the Insurance Carriers again introduce unilateral judgment over how the “usual and customary amount” for a particular service should be determined. In short, Clinicians do not know the “amounts” for other Clinicians—only the Insurance Carriers know the amounts for other Clinicians—and the substitution of “amounts” for “charges” reflects that the Insurance Carriers seek to have sole discretion to determine “reasonable amounts.”

**Annotation for I e:** For example, in Medicare Part B, the Patient’s co-insurance, after applying the deductible, is 20% of the Medicare allowable charge (e.g., if $1000 is the charge, and $800 is allowed by Medicare, then the Patient’s co-insurance is $160, or 20% of the $800 Medicare allowable charge). Co-insurance terms are defined in the Patient’s insurance agreement with his/her respective Insurance Carrier.

**Annotation for l f:** Co-payments are sometimes paid to and collected by the facility at the time of service. Co-payment terms are defined in the Patient’s insurance agreement with his/her respective Insurance Carrier.

**Annotation for l h:** For example, a $1000 charge with a $700 allowable charge and $500 deductible would result in $500 of the charges applied to the deductible (Patient responsibility), $140 applied to the co-insurance amount (presuming 20% of $700 – the Patient’s responsibility), $60 paid by the plan, and the $300 remainder billed to the Patient as a “balance bill” IF the Clinician was OON and balance billing of the claim was not restricted by state law. The deductible amounts are defined in the Patient’s insurance agreement with his/her respective Insurance Carrier.

**Annotation for l. i:** The Connecticut law was used as a reference but uses the terms “health carrier.” That term was avoided as the Medicare Part B contractors were for decades known as “Carriers” until they were renamed to be “Medicare Administrative Contractors or MACs”.

**Annotation for l. j:**  This OON benefit amount may be less than the benefit that the Insurance Carrier will allow for in network service.  Insurance Carriers may use this lower OON benefit as an incentive for Patients to utilize in network Clinicians. In certain OON circumstances, Insurance Carriers may refuse to recognize the Patient’s signed “assignment of benefits” to the Clinician, and send the OON allowable benefit amount (less coinsurance and deductible payments) to the Patient instead of directly to the Clinician.  Insurance Carriers may use both tactics to try to coerce Clinicians to contract with the plan.  Plans should honor assignment of benefits, and base their OON benefits on Clinicians' usual and customary charges for these services.  Since contracted Clinicians discount their services to the plan in exchange for contract considerations, like faster payment, plans should be reimbursing higher, not a lower, benefit for OON services.

**Annotation for l. r:** The POS definitions above are quoted directly from CMS and as they appear in CPT. POS codes are required under the HIPAA Transactions and Code Set Standard Regulations by Clinicians who code and bill for their professional services to all payors who accept and receive electronic transactions via the ANSI 837-P or CMS 1500 claim form. The POS codes are a prerequisite for reimbursement of Clinicians’ services.

**Annotation for l. s:** For example, assume a Clinician’s $1000 actual charge and the Insurance Carrier’s OON allowable is $450. The Patient would be responsible for paying the “balance bill” or a total of $550. If the Patient’s co-insurance payment for the ED Clinician’s services is 20% of $450 or $90, and the plan pays $360 ($450 OON allowable less the $90 co-insurance), then the Actual Charge ($1000) minus the Patient’s cost sharing (co-insurance of $90) leaves $640 ($1000 charge less the OON allowable of $360) as the OON balance billing amount. Although the $90 co-insurance payment can be billed, certain states restrict the right of the Clinicians to bill the $550 remainder and would require that this remainder be written off. If the same facts are present as noted above, but the Patient was In-Network, the issue of OON balance billing usually doesn’t arise due to prospective contractual adjustment arrangements between the Insurance Carrier and the Clinician.

**Annotation for l. t:** Pursuant to the Patient’s health insurance policy, the co-insurance percentage for elective OON services is generally greater than for in network services, but per the ACA, Patient cost-sharing for emergency care must be the same for In- and Out-Of-Network services. Some Insurance Carriers specify different benefit amounts for In-Network and OON services. If the benefit amount is less, the Patient in turn is responsible for a greater portion of the unpaid balance after the OON allowable is applied. Some states restrict the right of the Clinicians to bill the Patient for the remaining balance of the charges after the OON allowable and Patient cost sharing are applied.

**Annotation to ll.: (Alternative language for ll)** Insurance Carriers shall reimburse directly to the Clinician all applicable charges for OON Services within thirty (30) calendar days of the submission of claim by the Clinician; If the guarantor has a valid assignment of benefit form (AOB), the payer must pay the provider directly.

**Annotation to ll.:** The services as “coded and billed” is to protect against potential “downcoding” or “payable diagnosis lists” that have been used in the past by payers.

**Annotation to lll. a:** If non-elective language proves difficult to use, substitution of EMTALA based services language may be considered.

**Annotation to lll: (Alternative language to lll.)** Insurance Carriers shall reimburse the Guarantor’s Cost Sharing amount directly to the Clinician and the Insurance Carriers may subsequently bill the Guarantor for the applicable Guarantor Cost-Sharing amount. Requiring the Insurance Carriers to reimburse the Patient’s cost sharing directly to Clinicians was adopted and promoted by the FL-ACEP (FCEP) and WA-ACEP state chapters, respectively.

**Annotation to lV. c:** The provisions above are adopted in part from the Connecticut (CT) law that applies the MBS only to ED services; the proposed OONML expands the MBS to POS 21 and 22. As with the CA law AB 72, there is an opt out as explained further below that permits the Clinician and Guarantor to opt out of the OON balance billing restrictions. The opt out addresses the “surprise billing” situation by requiring 24 hour advance notice, written estimate of charges and signed Guarantor consent in advance of services.

**Annotation to V. g:** The foregoing provisions are conceptually based on California’s recently enacted AB 72. That law addresses the “surprise bill” situation in the non-emergency context and provides essentially an opt-out of the law’s restrictions on OON balance billing where the Patient/ Guarantor is provided the legally required notice and written consent. Emergency services (POS 23 are never subject to an “Opt Out” by the Patient—these services would always be subject to an OON Balance Billing restriction. AB 72’s minimum benefit standard (MBS) provisions were changed in the model legislation document as the CA law ties the MBS to the greater of the in network rates (which Clinicians would not know but for disclosures by the health plans) and 125% of Medicare. As stated above, the Medicare fee schedule should never serve as the basis for an MBS.

**Annotation to Vl. j:** The foregoing was referenced to provisions in the TX state law, the ACEP/EDPMA JTF Strategies White Paper and the WA-ACEP Balanced Billing / Surprise Coverage Proposal. The factors listed in c. above are taken from the so-called “Gould Criteria” in California and are published by the CA Dept. of Managed Health Care as factors used to determine if Insurance Carriers reimburse “reasonable and customary” amounts to Clinicians. The adoption of the 30 day resolution and bundling of claims are expressly intended to disincentive Insurance Carriers from unnecessary and lengthy mediation tactics.

**Annotation to Vll.:** Insurance Carriers have in the past used misleading statements in their EOBs to Patients for OON reimbursements, claiming that they have paid “XX%” of Medicare and have paid the providers fairly or the “usual, customary and reasonable” payment. The plans have instructed Patients to involve the plans if the Patients are in turn sent an OON balance bill and that the plans will address issues with the providers. When providers attempt to engage Insurance Carriers, the plans indicated that providers are OON and the plans will not communicate with the providers or their representatives. ACEP has, with the support of an ED group, challenged and successfully settled disputes with the Insurance Carriers over misleading EOBs, through the “compliance dispute” process established by the Thomas/Love class action cases filed by the AMA and select state medical societies.

**Annotation to Vlll. c:** States vary greatly in terms of which medical board and regulatory agency has jurisdiction over non-compliance issues. The key for Clinicians is to avoid CT’s statute that sets up a potential litigation trap for Clinicians who may have an OON bill sent to a Patient and then find themselves in potential treble damages and attorney fees litigation for “false and deceptive” trade practices. Medical boards have existing infrastructure to address physician group practices that are alleged to be in violation of the law and the state department of insurance could also have co-jurisdiction for enforcement over both Insurance.