

NATIONAL CONFERENCE OF INSURANCE LEGISLATORS
SPECIAL HEALTH, LONG-TERM CARE & HEALTH RETIREMENT ISSUES
COMMITTEE ROUNDTABLE ON BALANCE BILLING REGULATION
PHILADELPHIA, PENNSYLVANIA

JULY 9, 2009

MINUTES

The National Conference of Insurance Legislators (NCOIL) Health, Long-Term Care & Health Retirement Issues Committee met at the Marriott Downtown in Philadelphia, Pennsylvania, on Thursday, July 9, 2009, at 9:45 a.m.

Sen. Ann Cummings of Vermont, chair of the Committee, presided.

Other members of the Committee present were:

Sen. Ralph Hudgens, GA
Sen. William Haine, IL
Rep. Ronald Crimm, KY
Rep. Barb Byrum, MI
Rep. Marc Corriveau, MI
Rep. George Keiser, ND
Rep. Donald Flanders, NH
Rep. Dan Dodd, OH
Rep. Brian Kennedy, RI
Rep. Larry Taylor, TX
Sen. Mike Hall, WV

Other legislators present were:

Sen. Chris Steineger, KS
Rep. Dennis Horlander, KY
Sen. Jerry Klein, ND
Rep. Frank Wald, ND
Rep. Charles Curtiss, TN
Rep. Kathleen Keenan, VT

Also in attendance were:

Susan Nolan, NCOIL Executive Director
Candace Thorson, NCOIL Deputy Executive Director
Michael Humphreys, NCOIL Director of State-Federal Relations
Jordan Estey, NCOIL Director of Legislative Affairs & Education

CONSUMER PERSPECTIVE

Ellen Kuhn of the Maryland Attorney General's Office out-of-network health insurance arrangements and how consumers often misunderstand their financial responsibilities from unexpected "balance bills." She said these bills are the unpaid difference between a doctor's charge for a service and the amount an insurance company pays under a consumer's health

plan. She said the consumer is responsible for this unpaid portion, which can often be thousands of dollars.

Ms. Kuhn said that under managed care networks, in-network providers have negotiated contracts and payment rates with an insurer, while out-of-network providers do not. She said managed care arrangements lowered costs by encouraging consumers to seek treatment within their insurance plan's network. She said that most consumers know they face additional fees when they go outside of the network, but there was a lack of transparency, however, about what providers are in their network and how much is owed for treatment outside the network.

Ms. Kuhn described a common scenario for consumers to highlight the confusing nature of out-of-network medical bills. She said most out-of-network consumers think they will owe a deductible and a co-insurance percentage of a total medical bill. She said insurers, however, only pay a percentage of a pre-determined "allowable amount," not a fixed percentage of the doctor's full bill. She gave an example of a doctor charging a patient \$1,200 for a service. She said if the patient has 20 percent coinsurance, they expect the insurer to cover 80 percent of that charge. She said, however, if the insurer's allowable amount for this treatment is \$800, then they pay the provider \$640 (80 percent of \$800). She said the consumer in this example would be billed the difference between the \$1,200 bill and the \$640 reimbursement instead of a much smaller payment that they expected to pay. She said many consumers also falsely assume that the provider will absorb the unpaid portion of the bill.

Ms. Kuhn said health maintenance organization (HMO) enrollees often need a referral from a primary care physician before they can go out-of-network, which keeps most enrollees in the network. She said preferred provider organizations (PPO) consumers, however, have the flexibility to pick and choose their providers without consulting a primary care physician.

Ms. Kuhn said many problems occur in hospital and emergency room settings. She said patients with serious emergencies don't choose where they are admitted and what doctors will treat them. In minor emergencies, she said, consumers will seek care at hospitals in their network, but are often unaware that certain hospital physician groups aren't contracted with the same insurers. She said consumers, in these situations, face separate and unexpected bills from each of these groups and their hospital.

Ms. Kuhn said consumers seeking information prior to surgery have struggled to find information about these non-contracted provider groups working at in-network hospitals. She said a number of different providers could bill the consumer for their services on a surgery, including specialists such as lab technicians and anesthesiologists, among others. She cited a personal surgical experience where she could not determine if a hospital's anesthesiologist was contracted with her insurance plan, despite repeated calls to her insurer and hospital.

Ms. Kuhn said out-patient settings experience fewer problems than hospitals, but she said, there were fewer specialists in rural areas, which poses access problems, as rural specialists are less likely to have contracts with insurance companies.

Ms. Kuhn said Maryland prohibited providers from balance-billing HMO enrollees. She said insurance companies and providers also had to, by contract, hold HMO enrollees harmless.

She said the Maryland law, however, doesn't address out-of-network issues faced by enrollees of PPOs, who were more likely to be balance-billed.

In closing, Ms. Kuhn said legislators could consider extending balance billing prohibitions to PPO consumers or limit the prohibitions to emergency and certain hospital settings. She said that alternatively, legislators could consider statutory reimbursement rates for out-of-network providers.

STATE REGULATOR PERSPECTIVE

Dianne Longley of the Texas Department of Insurance (TDI) detailed her state's efforts to address out-of-network balance billing issues. She briefly overviewed the private health insurance market in Texas, noting that three-quarters of all plans sold were PPOs. She said PPOs were the source of the most confusion and agreed with Ms. Kuhn that healthcare facilities, such as hospitals and emergency room settings, were problematic for consumers.

Ms. Longley said a 2007 Texas law, S.B. 1731, had created new transparency and disclosure requirements for hospitals, providers, and insurers. She said, among other things the new law required HMOs and PPOs to:

- notify enrollees that a facility-based provider may not be in the plan's network, even though a facility is
- notify enrollees that an out-of-network facility-based physician may balance bill the enrollee
- upon request, provide enrollees with estimates of what the insurer will pay for proposed healthcare services or supplies
- upon request, provide an estimate of what the insured will owe for proposed services or supplies
- upon request, provide information on whether a physician/provider is in-network

Ms. Longley said the law required written disclosures at policy issuance or renewal, with any explanation of benefits (EOB), and on a plan's website. She said EOBs had to show when payments to out-of-network providers were paid at usual, customary, and reasonable (UCR) amounts and provide a toll-free TDI telephone number for consumers.

Ms. Longley said the law required insurers to provide additional information about facility-based providers on their Website, including a list of in-network facilities that use out-of-network providers. She said this was challenging for health plans because contracts between hospitals and their providers change constantly. She said states could establish clearinghouses through their department of insurance where information on hospital contracts could be gathered and then accessed by consumers and insurers.

Ms. Longley said S.B. 1731 also established a stakeholder advisory committee to collect data among HMOs and PPOs and to review the scope of balance billing problems. For PPO plans, she said, the committee found that:

- 14 percent of billed charges and 15 percent of allowed charges were out-of-network
- emergency settings accounted for 28 percent of out-of-network claims
- radiologists accounted for 12 percent of out-of-network claims

- neonatologists accounted for 11 percent of out-of-network claims
- pathologists accounted for 5 percent of out-of-network claims
- the total potential for balance billing amount was \$44,415,781

Ms. Longley said that, as expected, the potential for balance billing was much smaller among HMO enrollees. She said, among other things, that the advisory committee found that only nine percent of billed charges were for out-of-network services and the potential for balance billing in HMO settings was only \$9,080,105.

Ms. Longley said a 2009 law, H.B. 2256, put in place additional consumer protections. She said the law established a mediation process, upon request, for consumers facing out-of-network claims above \$1,000, and that:

- health plans and physicians must participate in the mediation process or face penalties
- physicians can avoid mediation if they notify a patient of his/her expected payment before services are provided and the billed amount is less than or equal to the estimate
- mediation fees are shared by physicians and insurers
- unresolved mediations are referred to a special judge for decision

Ms. Longley said H.B. 2256 also directed the Texas Commissioner of Insurance to, by rule, adopt network adequacy standards to ensure availability of and accessibility of a full range of contracted physicians and providers. She said any legislative solution to address the balance billing and out-of-network charges must also include network adequacy standards.

PROVIDER PERSPECTIVES

American Medical Association (AMA)

Catherine Hanson on behalf of the AMA said there was a lack of transparency regarding how health insurers price their products, organize their provider networks, and interact with providers who are non-contracted or out-of-network. She said, among other things, that:

- consumers don't receive the benefit of higher premiums charged for out-of-network insurance products, such as PPOs
- low insurer payments to out-of-network providers unfairly burden patients
- there was a lack of information about contracted networks and out of network policies
- networks were inadequate and failed to meet the needs of enrollees

Ms. Hanson said these problems were interconnected and all contributed to patients being balance-billed a disproportionate share for out-of-network healthcare expenses. She said, if unaddressed, these practices would continue to create significant cost and access problems for patients.

Ms. Hanson said that banning a provider's right to balance-bill patients would force doctors to engage in costly disputes with insurers over fair payments when there is no contract. She said these prohibitions would increase the already dominant market power of health insurers throughout the country by:

- giving them power to unilaterally set the rates of physicians who are not contracted
- eliminating any incentive or need for insurers to contract with physicians on financially and ethically viable terms

Ms. Hanson said the AMA was working proactively on these issues and supported state regulatory solutions that would attack the root problems facing patients and physicians. She said the AMA's approach would require health insurers to:

- pay out-of-network benefits at the level they have promised
- clearly disclose, in plain language, the scope and limitations of any out-of-network benefits provided
- charge premiums that reasonably reflect the actuarial value of out-of-network benefits
- maintain transparent and adequate networks of contracted providers
- provide accurate, comprehensive information about contracted physicians—including hospital-based physicians—in provider directories

American College of Emergency Physicians (ACEP)

Dr. Michael Gerardi with ACEP said emergency providers are required by the federal *Emergency Medical Treatment and Active Labor Act (EMTALA)* to treat patients regardless of their ability to pay. He echoed Ms. Hanson's comments and said that emergency providers were also underpaid by health plans. He said low insurance reimbursements combined with a federal mandate to treat all patients strained emergency rooms and their providers. He said insurers, among other things:

- deny payment for arbitrary reasons and allow no fair recourse for dispute
- assign reimbursements to patients, who commonly receive the checks and don't pay the physician or hospital
- use faulty databases to establish artificially low usual, customary, and reasonable (UCR) rates

Dr. Gerardi said a fair payment system would benefit all interested parties, including patients that depend on a functional emergency care system. He overviewed an ACEP *Fair Payment for Emergency Physician Services Model* that would prohibit non-contracted providers from billing out-of-network patients for medically necessary services. He said the model would, in turn, establish fair reimbursement rates for non-contracted providers and a dispute resolution process through an independent entity.

INSURER PERSPECTIVES

America's Health Insurance Plans (AHIP)

Rick Ramsay of America's Health Insurance Plans (AHIP) said all fifty states had laws dealing with the issue of balance billing, but their scope and specific requirements varied widely. He said:

- thirty-three states prohibited contracted providers from balance billing enrollees
- twelve states further extended these bans to prevent non-contracted providers from balance billing enrollees in certain circumstances

- some states extended the judicial rule of implied contracts to non-contracted providers rendering services in a contracted facility
- the federal government and states prohibited the practice of balance billing in the Medicare and Medicaid programs

Mr. Ramsay said consumers faced unexpected charges in several out-of-network situations, and that each posed unique problems. He said legislators should carefully consider the scope of the issues and how to best approach a legislative solution. He said legislative solutions requiring carriers to pay an out-of-network provider's billed charges in full—instead of the insurers' allowable amounts—would erode network benefits, increase costs, and decrease quality.

Mr. Ramsay questioned how to appropriately define “fair” reimbursement for out-of-network providers. He said common methods included the use of Medicare fee schedules, a percentage of Medicare, or UCR rates by region. He said the issue being discussed by legislators—especially in relationship to non-emergent care centers—was transparency and disclosure to consumers. He said AHIP supported these concepts and would support NCOIL's efforts to this end. He said meaningful transparency relating to hospitals and providers includes, among others:

- requirements of hold harmless provisions prohibiting providers from putting patients in the middle
- disclosure to consumers by facilities and providers that consumers may receive services from out-of-network providers
- mediation processes

Mr. Ramsay noted that Texas and Florida had developed transparency and disclosure laws. He cautioned that legislators and regulators should consider the antitrust concerns that arise from too much disclosure.

Council for Affordable Health Insurance (CAHI)

Kevin Wrege on behalf of CAHI said out-of-network charges and the issues surrounding balance billing were complex. He said any legislative solutions that prohibit balance billing or hold the consumer harmless would hurt the doctor and insurance carriers. He said neither of these “crude” approaches were reasonable, and urged the Committee to instead focus on transparency.

Mr. Wrege said transparency and disclosure were not silver bullets, but would help consumers. He reiterated Mr. Ramsay's antitrust concerns, but said insurance carriers had every incentive to work with legislators, hospitals, and providers to provide transparent information about who is in a network and who isn't.

Mr. Wrege said hospitals—a key interested party—were not at the table. He said any meaningful discussion about out-of-network charges and the hospital contract issues being discussed would need a hospital perspective. He also cautioned legislators against any top-down solution to these problems because state markets differ.

LEGISLATOR DISCUSSION

In response to a question from Assem. Calhoun about the best approach to prevent unexpected out-of-network balance bills from facility-based providers, Ms. Hanson said hospital-based physicians would benefit from network adequacy requirements. She said these providers want to be contracted with insurance networks, but only at fair rates.

Ms. Longley said few hospitals in Texas had facility-based providers that weren't contracted with any insurance network. She said issues occur when these providers don't have contracts with all insurance networks in an area. She gave examples of an anesthesiologist in a region that has contracts with only six of eight local insurance carriers. She said hospitals sometimes offer exclusive contracts that further contribute to the problems.

Sen. Hall said network adequacy was a big issue and that West Virginia had developed various measures to increase access to primary care physicians and other doctors. Mr. Wrege and Ms. Kuhn agreed, and urged legislators to follow federal healthcare reform discussions closely. Ms. Kuhn said measures being developed in Congress sought to increase access to primary care physicians. Mr. Wrege said if federal healthcare reforms pass, they will fundamentally change the healthcare landscape. He said legislators should be aware that the balance billing discussion could be entirely different if Congress enacts landmark reforms.

In response to Ms. Kuhn and Mr. Wrege's comments, Rep. Keiser expressed skepticism that the federal government would enact meaningful reform and noted that state legislatures needed to act regardless of what their federal counterparts do.

Rep. Taylor said the Committee was getting off track and that the issue was more about the myriad of healthcare interests trying to protect their own turf. He cautioned that increased government involvement—in the form of price-fixing and reimbursement rate-setting—would only complicate matters instead of fixing the problem. Sen. Hudgens agreed and said the government should let the market naturally evolve to fix these problems.

After continued legislator dialogue, Sen. Cummings said the Committee would discuss the issue further and determine NCOIL next steps on Sunday, July 12.

ADJOURNMENT

There being no further business, the Committee adjourned at 11:45 a.m.