American Society of Anesthesiologists®

Out-of-Network Payment:

The most confusing public health topic you'll ever love

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Chair, Ad Hoc Committee on Out-of-Network Payment

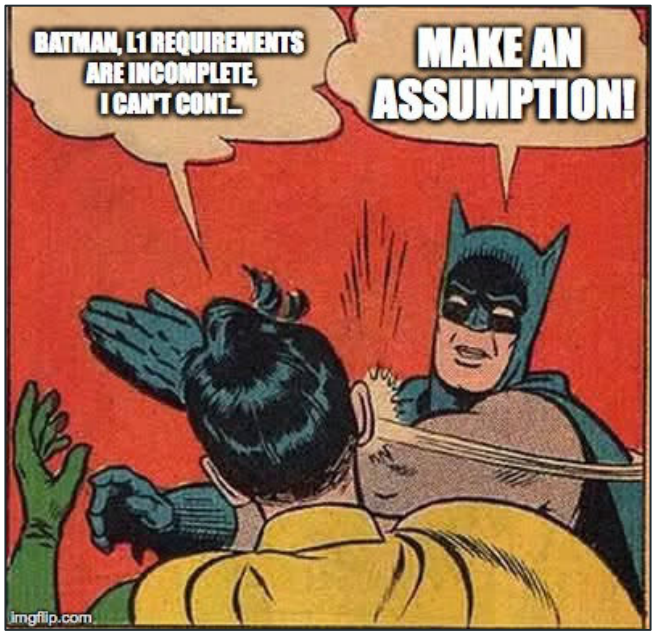
MSA SPRING CONFERENCE 2017
May 20th, 2017

CME Disclosure

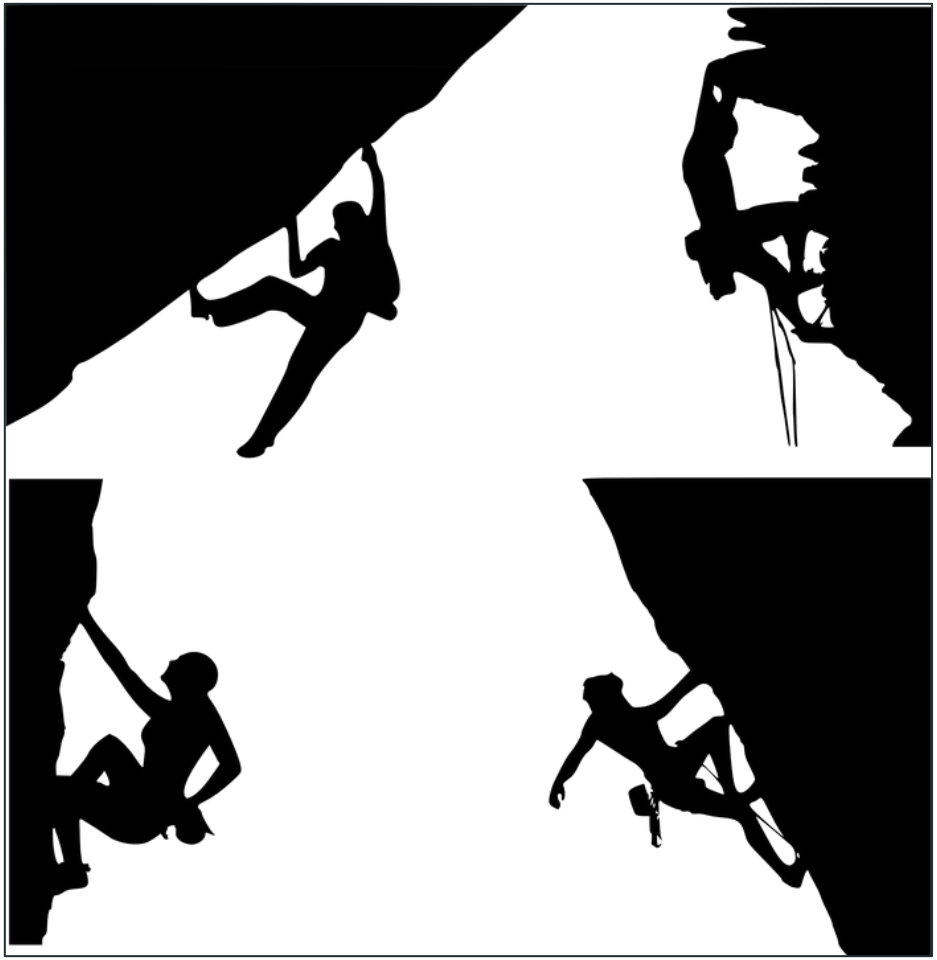
- Individuals involved in the planning and presentation of this activity have no relevant financial relationships to disclose
- This activity is presented free of commercial support

Today

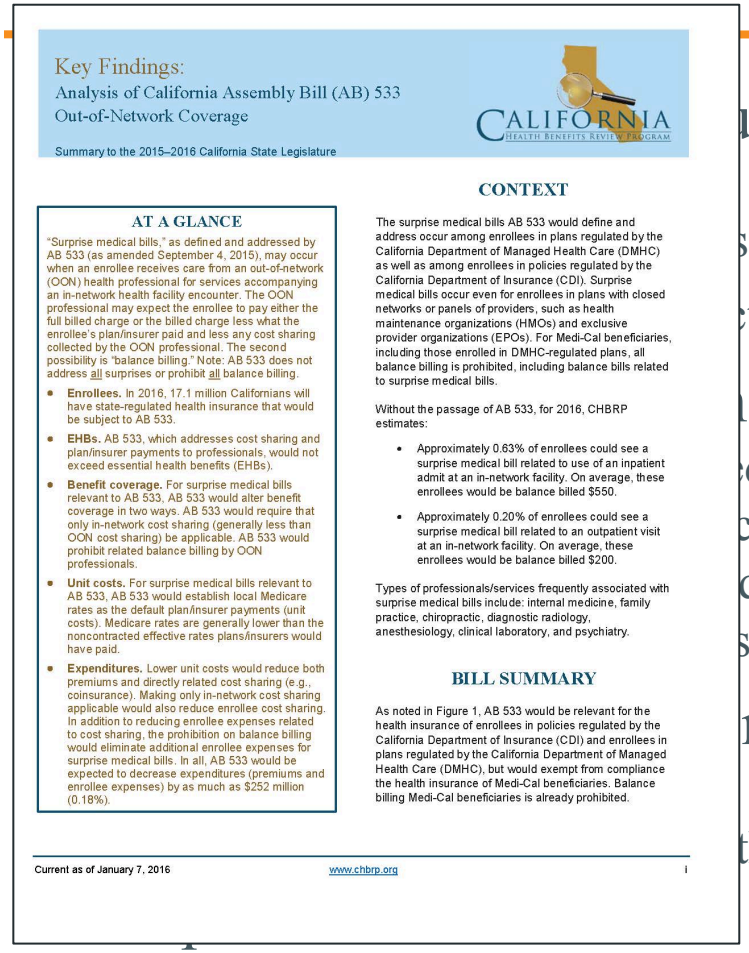
- Assumptions
  - Range of experience
  - Fundamentals
  - Solutions
  - Active learning experience
  - Key takeaway will be not to assume anything



Range of Experience



Fundamentals



Key Findings:
Analysis of California Assembly Bill (AB) 533
Out-of-Network Coverage

Summary to the 2015–2016 California State Legislature

CALIFORNIA HEALTH BENEFITS REVIEW PROGRAM

AT A GLANCE

"Surprise medical bills," as defined and addressed by AB 533 (as amended September 4, 2015), may occur when an enrollee receives care from an out-of-network (OON) health professional for services accompanying an in-network health facility encounter. The OON professional may expect the enrollee to pay either the full billed charge or the billed charge less what the enrollee's plan/insurer paid and less any cost sharing collected by the OON professional. The second possibility is "balance billing." Note: AB 533 does not address all surprises or prohibit all balance billing.

- **Enrollees.** In 2016, 17.1 million Californians will have state-regulated health insurance that would be subject to AB 533.
- **EHBs.** AB 533, which addresses cost sharing and plan/insurer payments to professionals, would not exceed essential health benefits (EHBs).
- **Benefit coverage.** For surprise medical bills relevant to AB 533, AB 533 would alter benefit coverage in two ways. AB 533 would require that only in-network cost sharing (generally less than OON cost sharing) be applicable. AB 533 would prohibit related balance billing by OON professionals.
- **Unit costs.** For surprise medical bills relevant to AB 533, AB 533 would establish local Medicare rates as the default plan/insurer payments (unit costs). Medicare rates are generally lower than the noncontracted effective rates plans/insurers would have paid.
- **Expenditures.** Lower unit costs would reduce both premiums and directly related cost sharing (e.g., coinsurance). Making only in-network cost sharing applicable would also reduce enrollee cost sharing. In addition to reducing enrollee expenses related to cost sharing, the prohibition on balance billing would eliminate additional enrollee expenses for surprise medical bills. In all, AB 533 would be expected to decrease expenditures (premiums and enrollee expenses) by as much as $252 million (0.18%).

CONTEXT

The surprise medical bills AB 533 would define and address occur among enrollees in plans regulated by the California Department of Managed Health Care (DMHC) as well as among enrollees in policies regulated by the California Department of Insurance (CDI). Surprise medical bills occur even for enrollees in plans with closed networks or panels of providers, such as health maintenance organizations (HMOs) and exclusive provider organizations (EPOs). For Medi-Cal beneficiaries, including those enrolled in DMHC-regulated plans, all balance billing is prohibited, including balance bills related to surprise medical bills.

Without the passage of AB 533, for 2016, CHBRP estimates:

- Approximately 0.63% of enrollees could see a surprise medical bill related to use of an inpatient admit at an in-network facility. On average, these enrollees would be balance billed $550.
- Approximately 0.20% of enrollees could see a surprise medical bill related to an outpatient visit at an in-network facility. On average, these enrollees would be balance billed $200.

Types of professionals/services frequently associated with surprise medical bills include: internal medicine, family practice, chiropractic, diagnostic radiology, anesthesiology, clinical laboratory, and psychiatry.

BILL SUMMARY

As noted in Figure 1, AB 533 would be relevant for the health insurance of enrollees in policies regulated by the California Department of Insurance (CDI) and enrollees in plans regulated by the California Department of Managed Health Care (DMHC), but would exempt from compliance the health insurance of Medi-Cal beneficiaries. Balance billing Medi-Cal beneficiaries is already prohibited.

Current as of January 7, 2016 www.chbrp.org i

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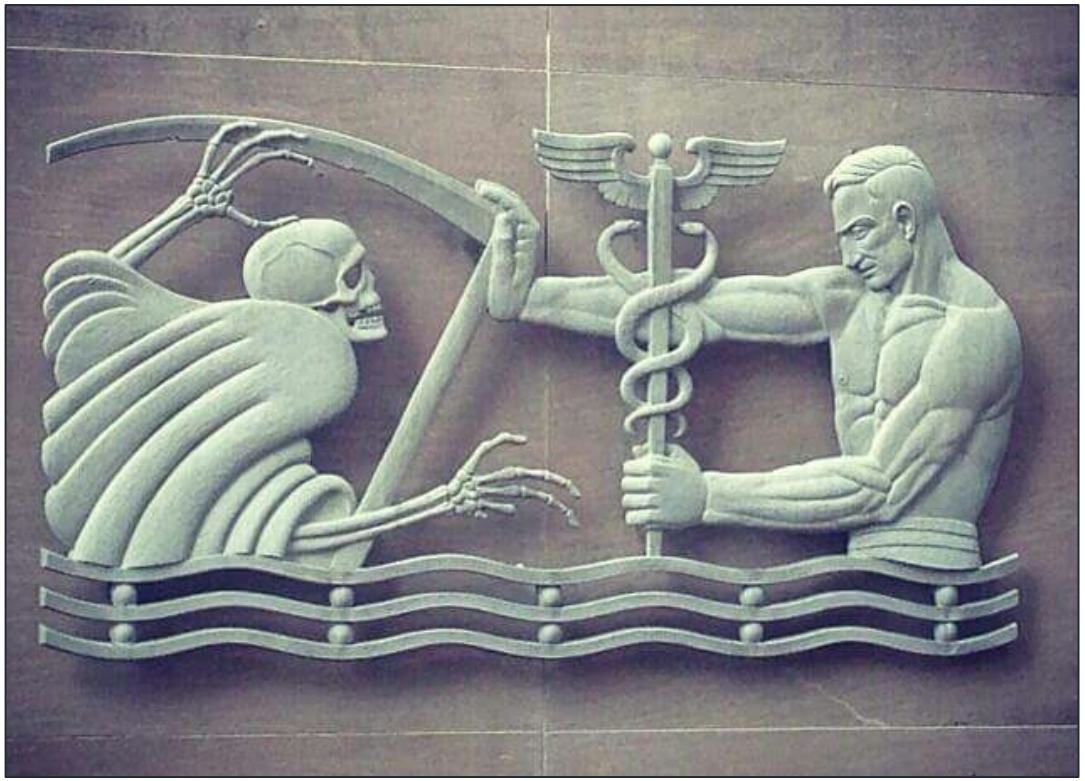
- This is a symptom of a much larger problem

This is Serious



Fundamentals

- Unlike any topic we have engaged in previously
  - A solution must be offered. Lawmaker look for simple solutions. Assume a fix without physician anesthesiologist input a loss
- Unbelievable preparation/coordination between insurance companies/consumer groups/labor
- Coordinated messaging/advocacy and strong multi- pronged approach required for success
- Consumer groups must be made allies and the focus should be on forcing a legislative solution for insurers' inappropriate/highly inadequate networks

State Level Advocacy

- Range of legislative proposals
  - Prohibitions on balance billing
  - Requirements for "good faith estimates"
  - Out-of-network disclosure/consent requirements for non-emergency services
  - Mediation triggered by a minimum price threshold
  - Tip: make sure to look for the benchmarking provision
- Nearly ½ the states considered legislation in 2016 & the vast majority in 2017
- Extraordinary media coverage

Advocacy Act

Collectively, then, provides persuasiv conclusion that Ae the on-exchange m complaint counties litigation position.

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Sherif Zaafran

Sherif Zaafran
Monday at 10:47 PM ·

To understand the fight we're fighting on behalf of our patients, it is important to understand that insurance companies will lie about losing money to justify increasing premiums on patients and reducing payment to physicians while reducing network adequacy. Here, Aetna was found to have lied about losing money and dropping 700,000 patients, just so it could blackmail the justice department to allow it's merger to go through! Physicians will always fight for our patients to receive fair access and insurance coverage!

U.S. judge finds that Aetna misled the public about its reasons for quitting Obamacare
latimes.com

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CS DISTRICT COURT
RICT OF COLUMBIA

Civil Action No. 16-1494 (JDB)

NDUM OPINION

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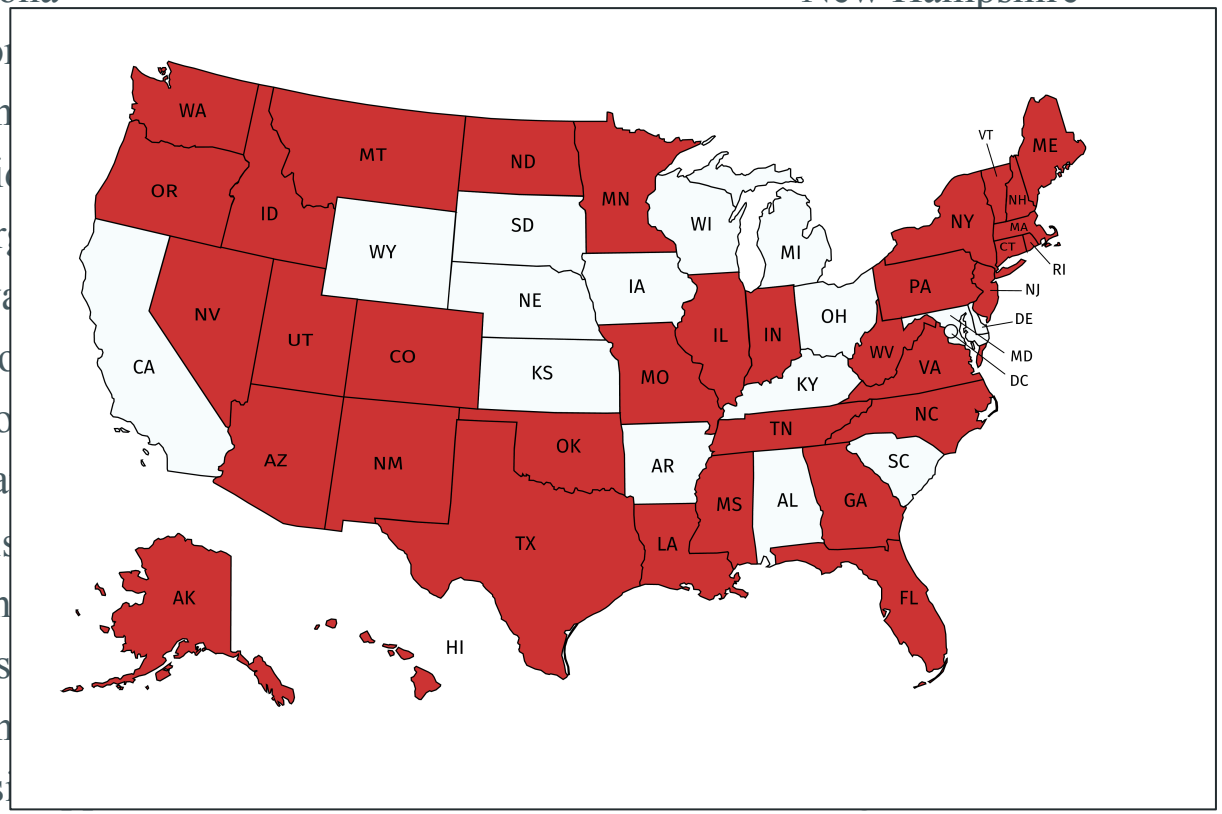
2017 Advocacy…So Far

- Alaska
- Arizona
- Colo
- Conn
- Flori
- Geor
- Hawa
- Idaho
- Illino
- India
- Louis
- Main
- Mass
- Minn
- Miss
- Missouri
- Montana
- Nevada
- New Hampshire
- Washington State
- West Virginia



Example of a Good Fix: New York 2014

"Usual and customary cost" shall mean the 80th percentile of all charges for the particular health care service performed by a 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 superintendent. The nonprofit organization shall not be affiliated with an insurer, a corporation…

2014 Sess. Law News of N.Y. Ch. 60 (S. 6914)

California & Florida -- 2016

California

Unless the patient agrees otherwise 24 hours in advance, insurance plans must pay out-of-network physicians:

- *The greater of the average contracted rate or*
- *125 percent of the amount Medicare pays for a fee-for-service basis for the same or similar service in the general geographic region in which the services were rendered*

2016 Cal. Legis. Serv. Ch. 492 (A.B. 72)

Florida

Reimbursement for services shall be ***the lesser*** of:

- The provider's charges;
- The usual and customary provider charges for similar services in the community where the services were provided (which is not defined in law and will be determined only if contested which involves a financial burden on the provider); or
- The charge mutually agreed to by the insurer and the provider within 60 days of the submittal of the claim

Laws of Florida Ch. 2016-222

Idaho -- 2017

NO NETWORK ADEQUACY / BALANCE BILLING LEGISLATION IN 2017

As previously reported, the Idaho Department of Insurance (DOI) drafted legislation several months ago to regulate the increasingly common practice of insurance carriers to form very narrow networks to save money. The DOI bill required network adequacy standards to ensure that patients could access the care for which they are covered by the health plans. The DOI legislation also had provisions to restrict balance billing by out of network (OON) providers, and offered minimal reimbursement in return.

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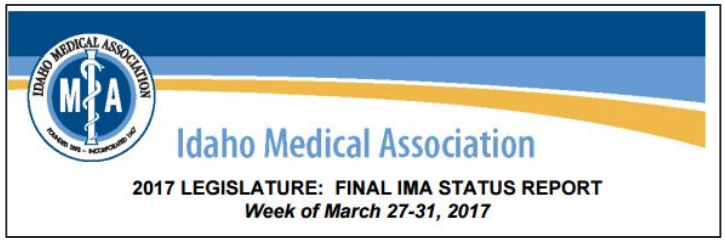
legislation.

> "…we were told definitively that DOI has pulled their bill for 2017."

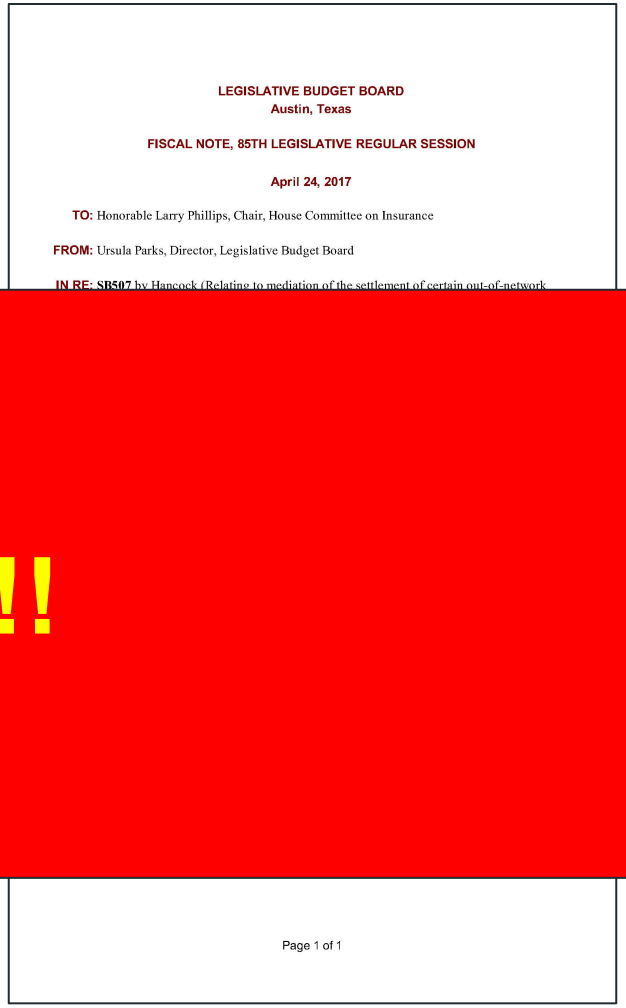
This week we were told definitively that DOI has pulled their bill for 2017. The bill will likely resurface in 2018 and IMA will continue efforts to educate DOI, the Governor's office and legislators about the problems with implementing government price controls on physician reimbursement. IMA is very grateful to all the physicians who have contacted us and taken action on the DOI bill – thank you! If you want to be included in future work on this issue, please contact IMA CEO Susie Pouliot at susie@idmed.org.



Texas -- 2017

Senator Hancock had this to say afterward:

> [W]ith the Senate's passage of SB 507, we're one step closer to expanding mediation protections to more Texas patients. This legislation would allow mediation of balance bills from all types of out-of-network providers treating patients at in-network hospitals and other facilities, including the booming industry of freestanding emergency rooms. I'm



LEGISLATIVE BUDGET BOARD
Austin, Texas

FISCAL NOTE, 85TH LEGISLATIVE REGULAR SESSION

April 24, 2017

TO: Honorable Larry Phillips, Chair, House Committee on Insurance

FROM: Ursula Parks, Director, Legislative Budget Board

IN RE: SB507 by Hancock (Relating to mediation of the settlement of certain out-of-network

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Passed!!

Red Alarm States

- Nevada
- North Carolina
- Oregon
- Washington State

Minnesota -- 2017

MN H 1129

Introduced on 2/13/2017 by Rep. Liebling (D)

This bill was assigned to the House Committee on Commerce and Regulatory Reform. It has not moved since it was assigned to this committee in mid-February. As introduced, it would make the state of Minnesota a single geographic rating area for individual health plans. It would also define "out of network referral center" and would require a health plan company to allow an enrollee to request access to an out of network referral center, at in network cost sharing (including any deductible, co-pay or co-insurance).

Status: has not passed first committee

MN S 2265

Introduced 3/27/2017 by Senator Abeler (R)

This bill was assigned to the Senate Commerce and Consumer Protection Finance and Policy Committee. It has not moved since it was assigned to this committee in late March. As introduced, the bill does not, however, require a health plan company to pay for services provided by an out-of-network provider, unless required under the plan, or provide coverage for a health care service that is not covered under the plan.

Status: has not passed first committee

Solutions

- **Medicare is not an appropriate benchmark for many medical specialties**

- Benchmarking to a non-conflicted / independent database of billed charges within a specific geographic region for a specific service is the preferred approach

- Maintaining an adequate network for all providers and all services is the key to solving the problem

- Where they fail to do so, hold insurance companies accountable to making payments based on real market values, thereby preventing patients from having to deal with grossly inadequate and surprise coverage

The Databases: Critically Important

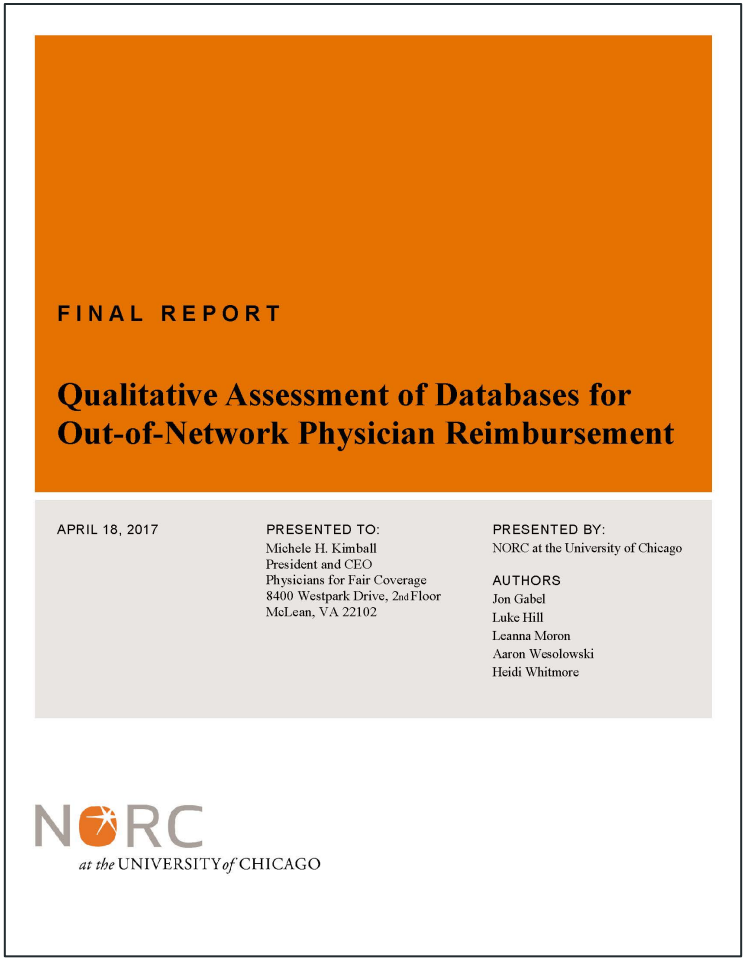
- FAIR Health
  - Established as a result of a lawsuit against the insurance carriers that were found to be deliberately manipulating data to their
  - When r
    the Fair Health database puts anesthesia where it should be – about 130% of average contracted rates
- HCCI
  - Health Care Cost Institute
  - Includes non-contracted and contracted rates which skews the data in a negative fashion
    ude:
    er
    Permanente; and United Healthcare

Difference Between Percentage and Percentile?

NORC Report

NORC finds that FAIR Health met the most criteria and recommends the use of FAIR Health as a reliable source of data for this purpose. Importantly, other vendors were not in the benchmarking business, and prohibited outside parties from using their data for benchmarking purposes. FAIR Health had the largest and most geographically widespread database. Use of FAIR Health data is less costly than other vendors. More specifically, our recommendation is based on these considerations:

- A national dataset with over 150 million covered lives.
- Both Commercial and Medicare claims.
- Data include allowed and billed charges.
- Easily accessible data and moderately priced.
- Transparency is its primary business.



Consensus Principles & Solutions Documents

CONSENSUS PRINCIPLES ON INSURANCE COVERAGE FOR OUT-OF-NETWORK CARE PROVIDED BY HOSPITAL-BASED PHYSICIANS

Supported by:
American Academy of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Radiology
American Society of Anesthesiologists
American Society of Plastic Surgeons
College of American Pathologists
Society of Hospital Medicine

When insured patients are treated in the hospital, they should be confident in the knowledge that their health insurance will cover them. Unfortunately, a growing number of these patients are finding out too late that their coverage is far less comprehensive than they thought. Increasingly, insurers are making unsuspecting patients responsible for additional payments of covered services provided by hospital-based physicians who are not in their insurer's network. Insurers have been further worsening this problem by enticing consumers to enroll in plans with ever-growing deductibles and ever-narrowing networks of providers. These are intentional business decisions by the insurers that allow them to reduce costs by shifting significantly more of the cost-sharing burden onto patients and by limiting the pool of physicians in their networks to those who agree to contract at greatly reduced rates that may be well below market value. Since the insurance industry is intensifying its efforts to narrow networks further and force more physicians out of network, we believe a fair and equitable solution to the out-of-network balance billing issue should be developed that protects unsuspecting patients from facing significant financial hardships simply because the hospital services they needed at that moment were provided by an out-of-network physician. The following shared principles of consensus are agreed to and will be supported by hospital-based physician specialties:

1. Insurers must meet appropriate network adequacy standards that include adequate patient access to specialty care, including access to hospital-based physician specialties. State regulators should uphold such standards in approving health insurance company plans.
2. All persons and entities involved in providing and financing health care have an obligation of transparency to patients and health care consumers. However, any discussion of transparency in the emergency setting must recognize that federal requirements under EMTALA statutes provide that patients seeking emergency care have unfettered access to a diagnostic evaluation and stabilizing treatment without regard to their ability to pay, thus appropriately restricting any discussion of costs and insurance status until a patient is stabilized.
3. The vast majority of physicians want to participate in network with insurance companies, but can only do so when insurers negotiate in good faith for fair reimbursement.
4. Insurers' high-deductible plans transfer more unexpected costs to patients who often choose options based on monthly premium costs without fully realizing the magnitude of their out-of-pocket expenses. The influx of large gaps in insurance coverage or "surprise bills" in this environment is as much the result of "surprise coverage gaps," as it is balance billing. Insurers must clearly inform their enrollees of the limits of their coverage and, prior to scheduled procedures, provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who unknowingly receive treatment from an out-of-network hospital-based physician should not be financially penalized by an unanticipated gap in their insurance coverage. The need for (and practice of) balance billing these patients can be eliminated if replaced with a fair and effective minimum benefit standard based on reasonable physician charges for the same service in the same geographic area.
6. Physician triggered mediation should be permitted in those instances where their unique background or skills (i.e. the Gould Criteria) are not accounted for within a minimum benefit standard.

PROPOSED LEGISLATIVE SOLUTIONS:
INSURANCE COVERAGE FOR OUT-OF-NETWORK CARE PROVIDED BY HOSPITAL-BASED PHYSICIANS

Supported by:
American Academy of Orthopaedic Surgeons
American College of Emergency Physicians
American College of Radiology
American Society of Anesthesiologists
American Society of Plastic Surgeons
Society of Hospital Medicine

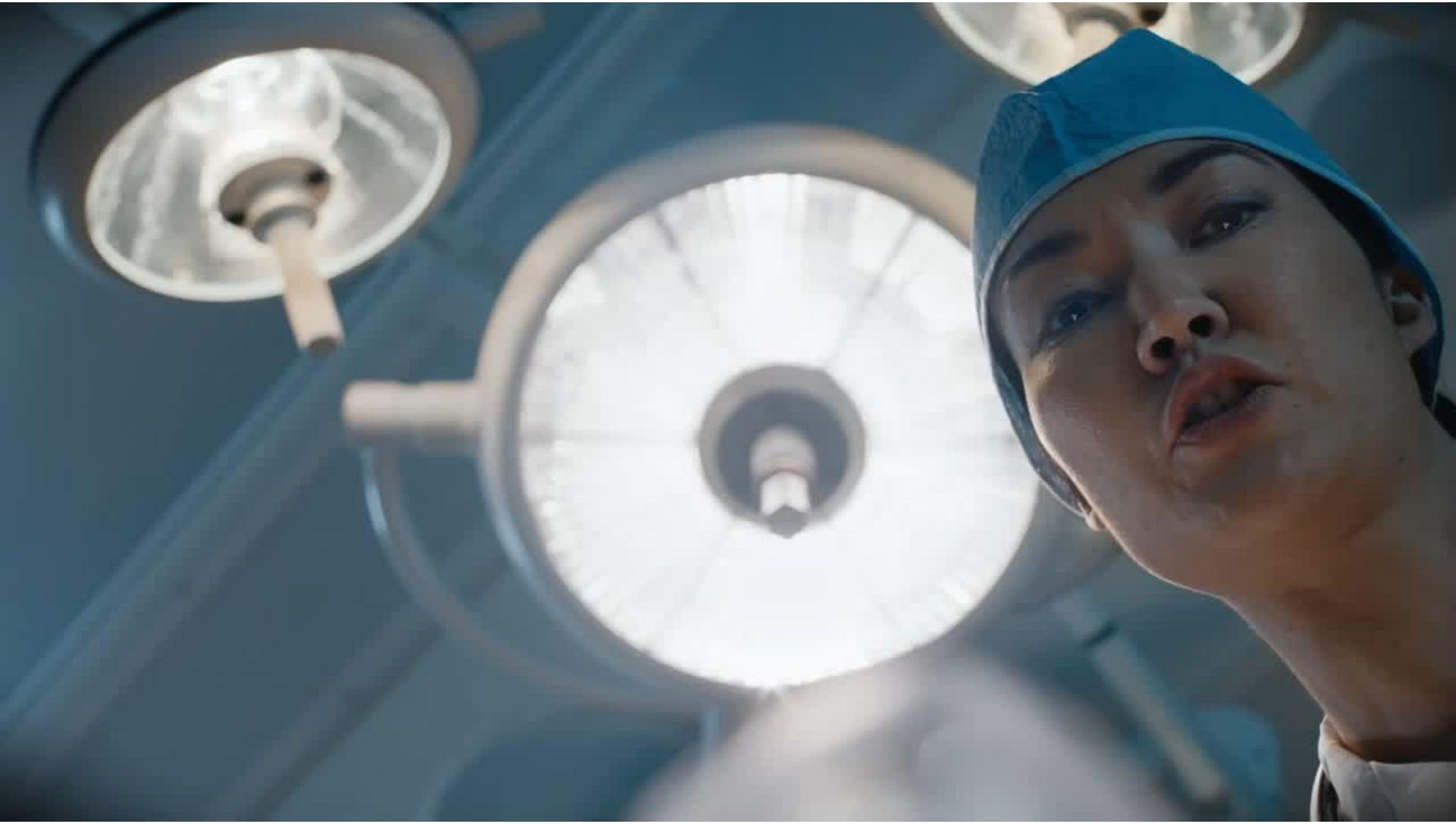
This document outlines those provisions that should be included in any legislation designed to address out of network reimbursement and some options for dealing with the issue. These suggested strategies are intended to be for general guidance only; state-specific laws/issues might mandate that some considerations be changed. States should take steps to assess what policies will work best in their given political climate. Consultation with knowledgeable counsel and professional advisors is highly recommended.

1. If legislation is likely to restrict balance billing, the following provisions should be included:
   a. A defined transparent, enforceable, and acceptable minimum benefit standard (MBS) for out of network services.
   b. With a Connecticut styled MBS, mediation may not be necessary as patients are protected from billing amounts (except for their co-insurance and/or deductible [collectively "cost sharing"]) and insurance companies must reimburse the MBS.[i]
   c. If an MBS is not achieved and mediation is required, a requirement that mediation be conducted by qualified professionals with healthcare claims experience, that it be resolved within 30 days of dispute submission, and that physicians can present multiple claims in a single hearing with an insurer so that they don't have to incur the time and expense of disputing each claim individually. Also any dollar threshold, above which mediation would be permitted, e.g. Texas, should be determined per CPT code and not per patient encounter. Plans should be prohibited from sending false, misleading, or confusing information in EOB's to patients.
   d. Insurers should be required to pay the health care provider directly rather than send the payment to their consumer and to pay the claims as billed and coded.
2. Provisions to consider including in legislation expressly prohibiting balance billing:
   a. Accepting a plan in which a minimum benefit standard for out of network payment is the 80th percentile of an independent database by geographic region (such as FAIR Health).
   b. Using a dollar threshold to define when an OON claim must be paid in full or is subject to mediation (e.g. Texas $500 threshold for health insurance companies, patients or providers to utilize mediation.[ii]) This threshold should be clearly defined to be **after**

Get Engaged, Take Action

- Get informed and educate your colleagues
- Develop / maintain relationships / educate your lawmakers
- Establish state OONP coalitions
- Activate the resources of your large group practice
- Ensure your state medical society is heavily engaged on this topic
- Respond to requests to submit letters of opposition/support
- Participate when asked to testify
- **Importantly: Engage ASA's Ad Hoc Committee on Out-of-Netwo**

  Payment!



Questions

Thank You

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