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Surprise Billing: Mediation Is Working And Needs To Be Expanded

June 1th, 2016

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Solving Network Disputes: Key Considerations

- **Texas has some of the strongest network adequacy standards in the country – all plans must meet network adequacy**
- **Out-of-network problems are generally isolated to three situations**
  - **Lack of providers or provider shortages**
  - **Out-of-network hospital-based providers practicing at a network hospital**
    - Often involving exclusive arrangements
    - Large provider groups - very little competition
  - **Emergency Care Services**
    - Emergency care providers/Freestanding ERs
- **These out-of-network problems occur regardless of plan or network size – systemic issue**

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Solving Network Disputes: Key Considerations

- **"Usual or Customary Charge" rule mandating health plans pay out-of-network ER providers based on "billed charges" has created an incentive for providers to stay out of network, exacerbated the out-of-network ER problem, and exposed more consumers to balance billing**
  - Problem with "billed charges:" Often have very little connection to underlying costs, quality, or market prices
  - Milliman predicted an increase in health care costs and the loss of hospital-based network providers due to the incentive to make more money out of network
  - 12 large ER provider groups terminated their contract with BCBSTX, citing it as a "business decision" after the 2013 rule implementation
- **There are still significant surprise billing problems related to emergency care and out-of-network hospital-based providers not included in the mediation statute**
- **Mediation is working but is limited and needs to be expanded**

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Surprise Billing Is Still A Problem

- **Additional Hospital-Based Providers:** Not all hospital-based providers are listed in statute - Surprise billing is increasing from other out-of-network providers, ex. “Hospitalists”
- **Emergency Care:** Data shows there is an out-of-network emergency care problem that needs to be addressed
- **Emergency Care Protections Are Inconsistent & Create an Incentive to Stay Out of Network:**
  - Current payment protections across product types are complex, confusing, and create an incentive for emergency care providers to stay out of network
  - Balance billing protections vary across product types, creating confusion
- **Transparency:** System is still too confusing for consumers; more transparency is needed on network status and prices (billed charges)

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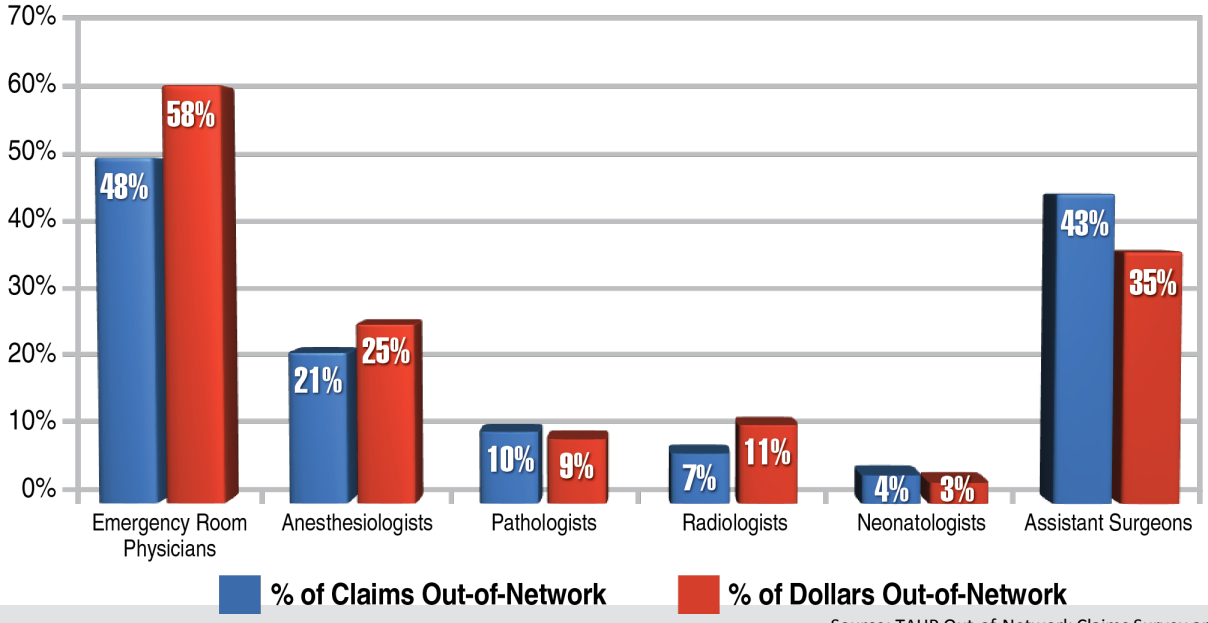
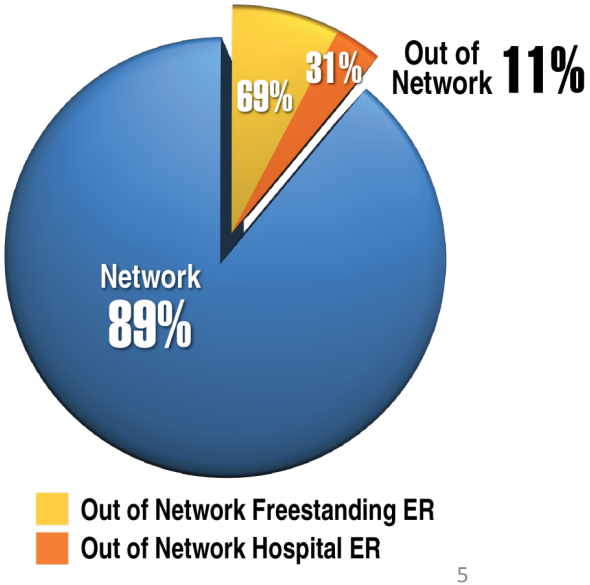
Emergency Services Are The Top Surprise Billing Problem: 2015

Percent of Claims & Dollars Out of Network: Hospital Based Physicians–2015



Emergency Room Facility Claims: Network vs. Out of Network



Source: TAHP Out-of-Network Claims Survey and Analysis of Three Large Texas Health Plans: 2015 Claims; May 2016

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Out-Of-Network ER Concerns

- **Emergency care payment protections are inconsistent & create an incentive to stay out of network**
- **TDI requires health plans to pay out-of-network providers based on billed charges, the "usual or customary charge" for emergency care**
  - Based on billed charges, not what is usually accepted & negotiated in the market
  - Creates a financial incentive for providers to stay out of network
  - Many ER providers have left health plan networks since U&C was adopted
  - Freestanding ERs tend to be out of network
  - 21% to 56% of hospitals have no in-network ER doc at in-network hospitals for the three largest health plans in TX
- **Providers can still balance bill patients in excess of the "usual or customary charge" payment**

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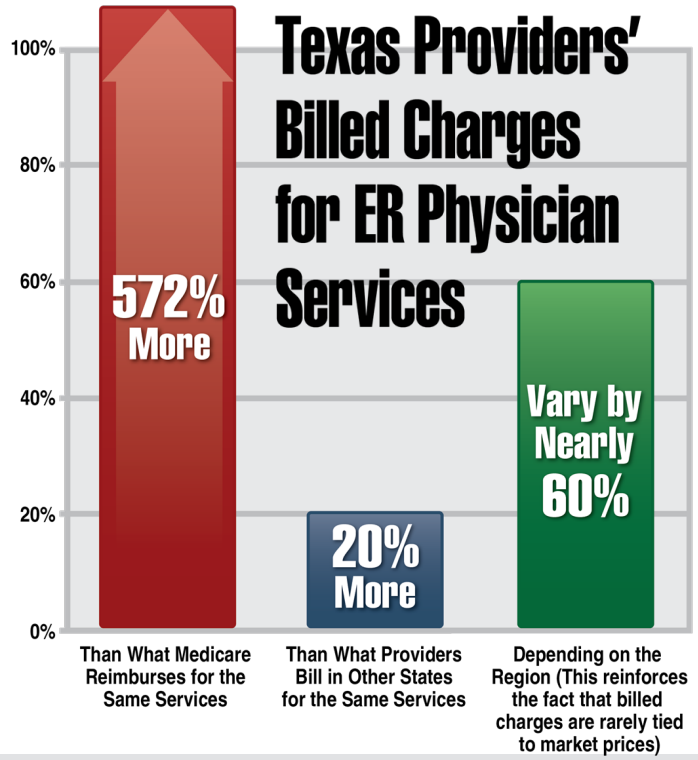
Concerns About Using Billed Charges

- **No limit to what a provider can charge**
- **Self-determined**
- **Often have very little connection to underlying costs, quality, or market prices**
- **Large variability**
- **Example: Texas providers' billed charges for a high acuity ER visit:**
  - 572% more than what Medicare reimburses for the same services
  - 20% more than what providers bill in other states for the same services
  - Can vary by nearly 60% depending on the region, reinforcing the fact that billed charges are rarely tied to market prices (25th vs. 75th percentile)



Source: Charges Billed by Out-of-Network Providers: Implications for Affordability, AHIP. Sept 2015

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Out-Of-Network Protections: Payments, Benefits, and Surprise Billing

Type of Plan	Out-of-Network Coverage	Out-of Network Payment Requirements (Texas)	Out-of-Network Payment Requirements (Federal)	Out-of-Network Benefit Coverage Protection	Balance Billing Protection
HMO	• Emergency Services • No Network Provider Is Available	• Usual and Customary Rate	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20)	• Hold Harmless
PPO	• All Covered Services	• Emergency Services & No Network Provider is Reasonably Available: Usual or Customary Charge (TDI Rule) • All Other Services: Allowable Rates	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20); credit balance billing amounts paid by enrollee to network deductible and out-of-pocket max • All Other Services: At Least 50% Benefit Coverage	• Physician Services Only: Mediation For OON Hospital Based Physicians (6 types) – Balance Bill Over $500 • No Additional Balance Billing Protection for Any Other Services
EPO	• Emergency Services • No Network Provider is Reasonably Available	• Usual and Customary Rate	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency & No Network Provider is Reasonably Available: In-Network Benefit Level (co-insurance percentage ex. 80/20)	• Hold Harmless
ERISA Self-funded Plans	• N/A	• N/A	• Emergency Only: Highest of In-Network Median Rates, Medicare, or Usual Allowable Rates	• Emergency: In-Network Benefit Level (co-insurance percentage ex. 80/20)	• No Additional Federal Balance Billing Protection

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Out-Of-Network Disputes Cause Surprise Billing

- Consumer receives out-of-network care (often unknowingly)
- No contract or negotiated rate is available
- Provider bills health plan at “billed charges”
- If out-of-network coverage is available, health plan pays amount covered by out-of-network benefits
- Consumer believes full payment has been made for services
- Surprise bill: Consumer receives a bill for the difference between the health plan’s out-of-network payment and the provider’s “billed charges” (The balance of the remaining bill or a “balance bill”)

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Surprise Billing: Current Mediation Protection

- **Individuals may request mediation of a non-network balance bill, if:**
  - PPO or EPO plan or the State ERS plan (TRS is not included)
  - Hospital was in the network
  - Non-network hospital-based physician
    - Radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, or assistant surgeon
  - "Balance bill" amount (per claim) is more than $500 (not including applicable copay, coinsurance or deductible amounts)
  - No notification of projected costs occurred or the amount billed to the consumer exceeds the projected amount
- **Provider is required to notify consumer of mediation protection on the "Surprise Bill"**
- **Plans are also required to provide notice of mediation (on EOB)**
- **Mediation forms on TDI's website: http://www.tdi.texas.gov/forms/consumer/mediationform.pdf**
- **History:** Mediation protection passed in 2009. In 2015, dollar threshold lowered from $1,000 to $500 and assistant surgeons added

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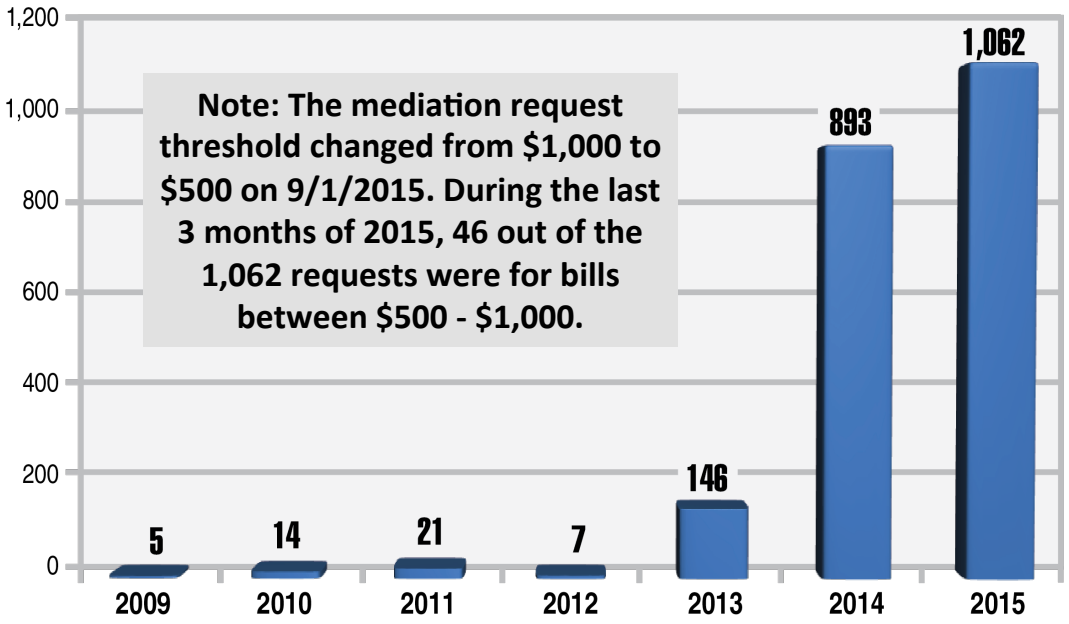
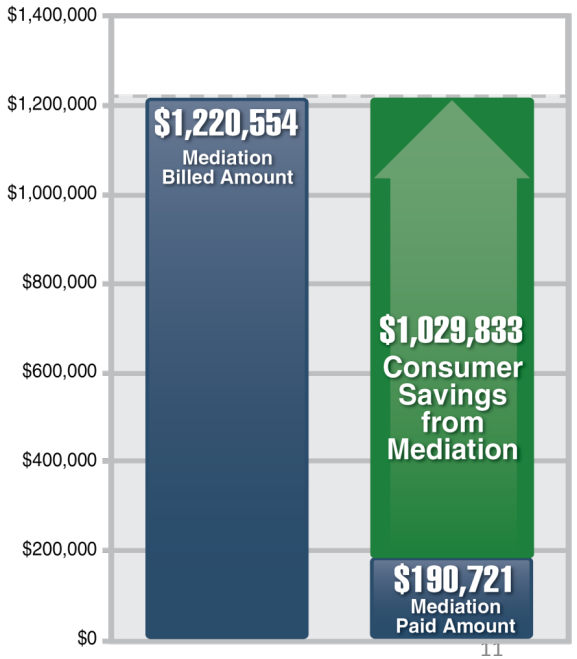
Mediation Is Working When Available

Total Number of Mediation Requests Received by TDI



Mediation Savings Impact to Consumers: 2015



Source: TDI Data On Out Of Network Mediation Requests , April 2016

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Recommendations

- **TAHP believes in a balanced approach that accomplishes three goals:**
  - Protect patients from bills they are not responsible for paying
  - Provide for fair and reasonable payment to out-of-network providers
  - Provide for a dispute process when providers feel they have not been accurately or adequately paid
- **Expand mediation and surprise billing protections for consumers for all out-of-network emergency care services – physicians, providers, and facilities**
- **Expand mediation protection for consumers who receive services from any out-of-network providers working at an in-network hospital**
- **Expand mediation to bills lower than the current $500 threshold**
- **Streamline emergency care protections, so they are uniform across all product types**
- **Set reasonable out-of-network payment standards for emergency care that do not create an incentive for providers to stay out of network – NAIC model recommendation**
- **Increase transparency of health care prices (billed charges) and network status**

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Appendix: Additional Information Related To Health Plan Networks And Balance Billing Protections

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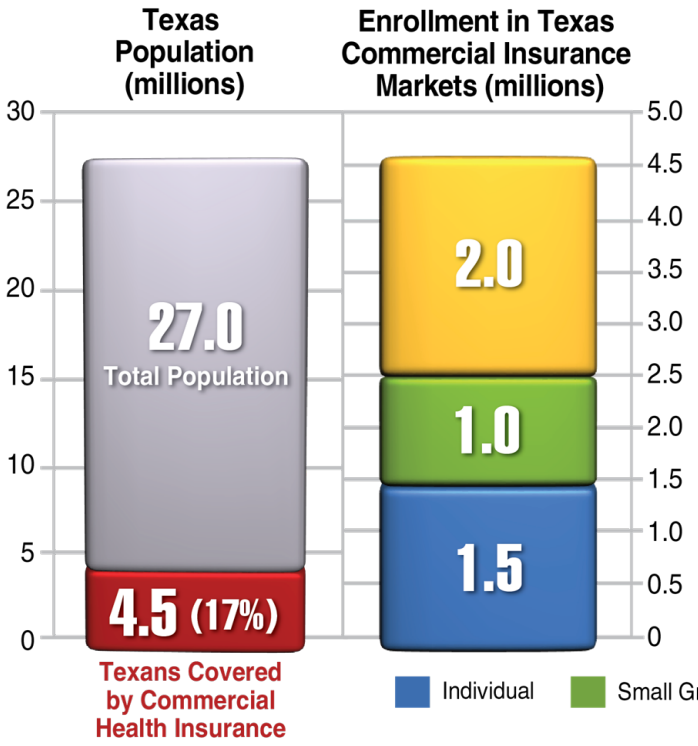
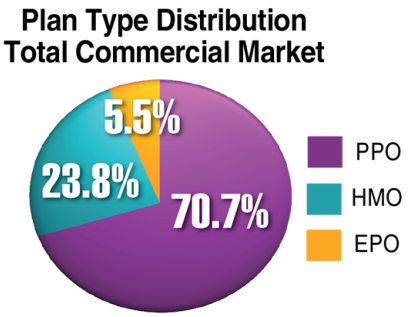
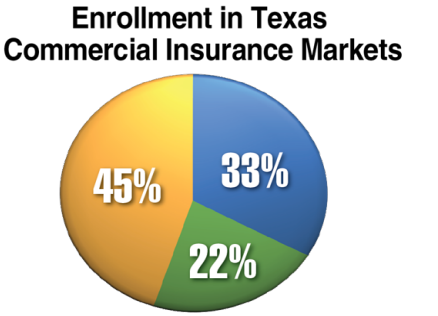
2015 Commercial Health Insurance Market In Texas

- Regulated by TDI
- Mainly Employer- Sponsored
- PPO
  - Most Purchased
  - Higher Premiums
  - Out-of-Network Benefits
  - Referrals not Required
- HMO
  - No Out-of-Network Benefits (Except ER & When Network Provider not Available)
  - May Include PCP Referrals
- EPO
  - No Out-of-Network Benefits (Except ER & When Network Provider not Available)
  - No PCP Referral Requirement







Source: TAHP Enrollment Survey 2015, Miliman Dec. 2015 & TAHP Addendum to 2015 Enrollment Survey, Milliman, April 2016

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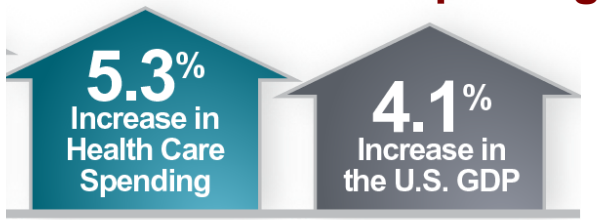
Why Health Plan Networks Are Important

- **Rising Health Care Costs: $3.1 Trillion Spent on Health Care in US in 2014**
  - 5.8% growth per year for the next decade
  - 2014: $1 in $6 was spent on health care
  - By 2024: $1 in $5 will be spent on health care
- **Health Plan Premiums Directly Track Health Care Costs**
- **Health Plan Networks**
  - Drive Competitive Price Negotiations
  - Hold Down Costs
  - Promote Quality
  - Protect Consumers From Surprise Billing and Inflated Billed Charge

2014 U.S. Health Care Spending



Source: National Health Spending, Health Affairs, January 2016

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Consumer Health Plan Trends

- Majority of consumers are satisfied with their health plans, costs, and their provider networks (Kaiser Family Foundation, May 2015)
- Nearly 90% of consumers are satisfied with the selection of providers from their health plans (Kaiser Family Foundation, January 2016)
- Only 12% of consumers have had to change providers in last 12 months (50% stated it was not a problem) (Kaiser Family Foundation, January 2016)
- 7 out of 10 exchange consumers said they had no financial difficulty paying for out-of-pocket medical expenses in the past yea. (Deloitte study, May 2016)
- A majority say their plan is an excellent or good value for what they pay for it (Kaiser Family Foundation, January 2016)
- A majority say they would have been unable to get or pay for that treatment without their new coverage (Commonwealth study, May 2016)

9 out of 10 Insured Adults
are Satisfied with Health Plan Networks

Source: Kaiser Health Tracking Poll January 2016

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Understanding Balance Billing: Two Patients With A Broken Arm Enter The ER Of An In-Network Hospital

	In-Network	Out-of-Network
Billed Amount From ER Doctor	$1,050	$1,050
Insurer's in-network contracted amount agreed to in advance	$500	N/A
Insurer's required out-of network payment based on what is usual and customary	N/A	$600
What your insurer pays	80% Coinsurance $500 x 0.8 = $400	80% Coinsurance $600 x 0.8= $480
Your coinsurance/cost sharing (same in-network and out-of-network)	20% Coinsurance $500 x 0.2 = $100	20% Coinsurance $600 x 0.2=$120
Balance Bill: *Difference between what the insurer paid (usual and customary) and what the physician charged*	None	$1,050 - $600 = $450
Total amount you owe: *Your coinsurance and balance bill*	**$100**	$120+$450 = **$570**

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Texas Department Of Insurance: Wait Times

- **EPO & PPO Wait Times**
  - ER - 24 hours a day, 7 days a week
  - Non-emergency, urgent care - within 24 hours
  - Preventive care - within 2 months for a child and 3 months for adults
  - Appointment for medical condition - within 3 weeks
  - Appointment or behavioral health conditions - within 2 weeks
- **HMO Wait Times**
  - ER Care - 24 hours a day, 7 days a week
  - Preventive health - within 2 months for a child, 3 months for an adult, and 4 months for dental services
  - Routine care - within 3 weeks for medical services, 8 weeks for dental conditions, and 2 weeks for behavioral health conditions
  - Urgent care - within 24 hours for medical, dental, and behavioral health conditions

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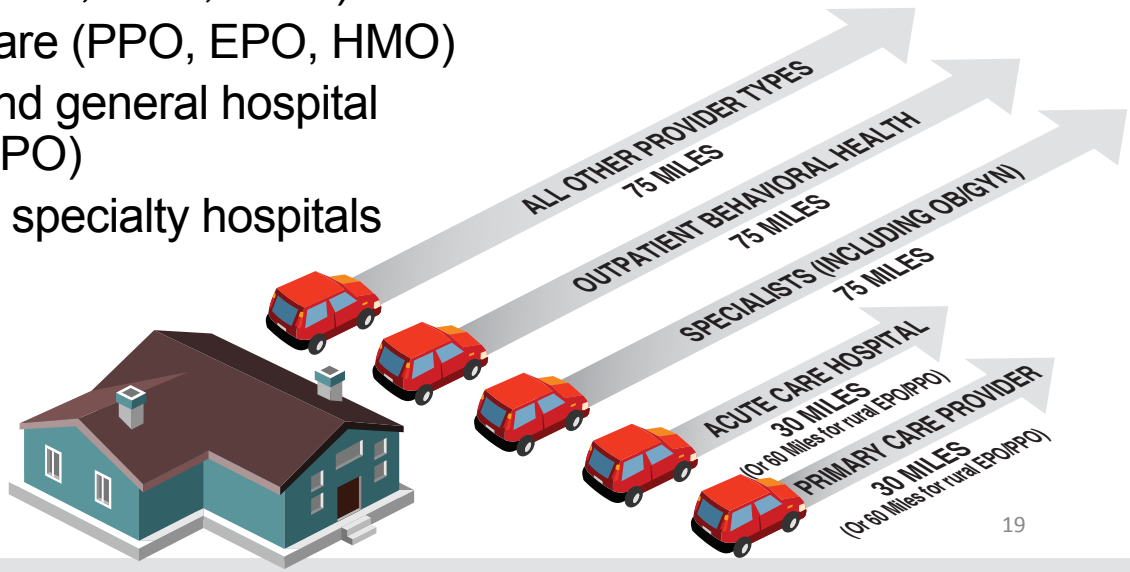
Texas Department Of Insurance: Distance Requirements

- **Maximum distance from any point in a health plan's service area:**
  - 30 miles for primary care (PPO, EPO, HMO)
  - 30 miles general hospital care (PPO, EPO, HMO)
  - 60 miles for primary care and general hospital care in rural areas (PPO, EPO)
  - 75 miles for specialists and specialty hospitals (PPO, EPO, HMO)



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Health Plan Transparency Requirements

- **Estimate of Payment**
  - Any deductibles, copays, coinsurance, or other costs (upon request of consumer, within 10 days)
- **Written notice to consumers that:**
  - Facility based providers may be out-of-network, even though they are at an in-network facility
  - Consumers may be charged the difference between what the health plan paid and the provider's full billed charges
- **Health plan provider directory and web site must clearly identify network hospitals in which facility-based physicians are not in the network**
- **Must identify payment to a non-network physician (EOB)**
- **Health plans report aggregate reimbursement rates, billed charges, aggregate contracted rate (for in-network providers) and aggregate allowed amount (for non-network providers) to TDI**
- **NOTE: Very few provider transparency requirements related to billed charges (prices) or network status**

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Consumer Out-of-Network Requirements

- **If a network provider is not reasonably available or for emergency care, PPO plan must:**
  - Pay usual or customary charges
  - Pay in-network level of benefits (in-network coinsurance level)
  - Credit any "balance billing" amount to the non-network deductible and annual out-of-pocket maximums
  - **Provider can still send a balance bill**
- **TDI enforces "hold harmless" protections against balance billing for EPO and HMO plan enrollees**

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Out-of-Network Provider Billed Charges in Texas: Compared to Medicare, U.S. Average, & Variation in Texas (2013 & 2014)

	Medicare Average Rate (Texas)	Average OON Billed Charges (U.S. Average)	Average OON Billed Charge (Texas)	Texas: % More than Medicare	Texas: % More than U.S. Average	% Difference in Charges in Texas (25th vs. 75th Percentile)
Critical Care 1st hour	$272	$795	$958	252%	21%	141%
Tissue Exam by Pathologist	$70	$227	$270	286%	19%	94%
Chemotherapy IV Infusion 1 Hour	$130	$437	$583	348%	33%	93%
Injection Therapy of Veins	$175	$446	$809	362%	81%	125%
Intensity Modulated Radiation Therapy	$387	$1,734	$1,893	389%	9%	106%
Emergency Department High Severity	$173	$971	$1,162	572%	20%	58%
MRI of Brain	$391	$2,919	$4,227	981%	45%	150%
Cervical/Thoracic Spine Injection	$109	$1,152	$1,401	1185%	22%	177%

Source: Charges Billed by Out-of-Network Providers: Implications for Affordability, AHIP. Sept 2015