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Balance Billing: Mediation is Working And Needs to Be Expanded

May 4th, 2016

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Texas Association of Health Plans

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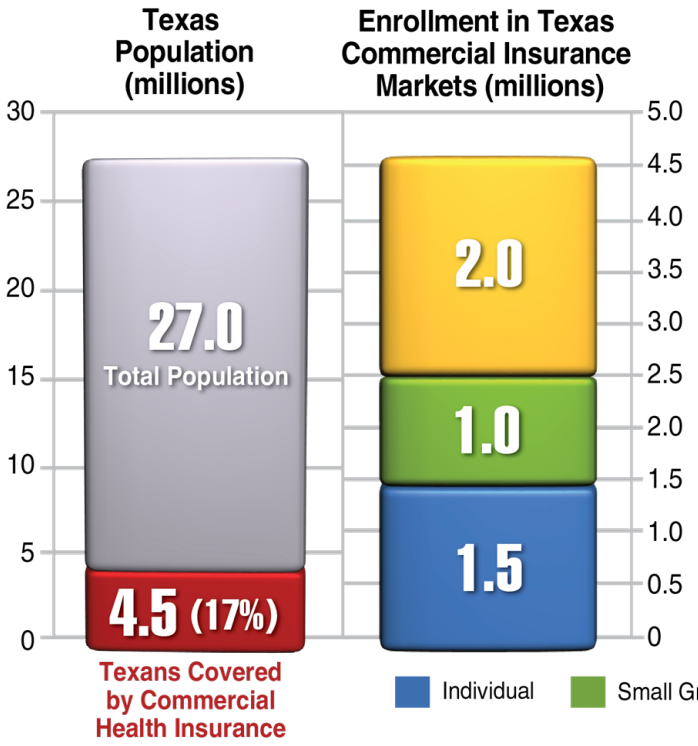
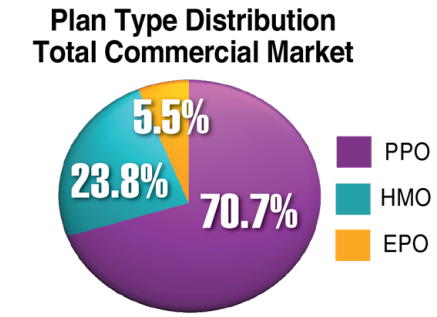
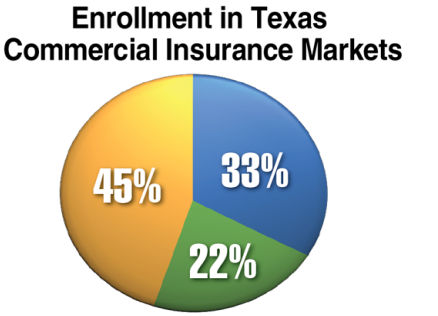
2015 Commercial Health Insurance Market in Texas

- 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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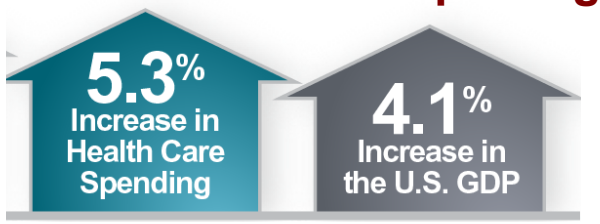
Why Health Plan Networks Are Important

- **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 With Health Care Costs**
- **Health Plan Networks Drive Competitive Price Negotiations**
- **Networks Hold Down Costs**
  - Contracted Rates vs. Billed Charges
  - Size of Network (5% to 20% Savings)
- **Networks Promote Quality**
- **Networks 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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In-Network vs. Out-of-Network

- There is a contract between the provider and the health plan
- Providers have agreed to see covered patients, creating access
- Providers have agreed to accept the health plan's contracted rate
- They have been selected based on the health plan's standards and requirements to ensure quality and safe care
- Providers agree not to "balance bill" patients
- Providers benefit from the volume of patients that are covered by the health plan

- No contract between provider and the health plan
- No agreed upon rate, so a provider bills the consumer at the full price or billed charges
- Health plans (PPO) have an out-of-network reimbursement schedule, which is often less than provider billed charges
- Providers are allowed to bill consumers (balance bill or surprise billing), for the difference between the health plan reimbursement and the provider's billed charges

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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 is more than $500
  - 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 TDIs 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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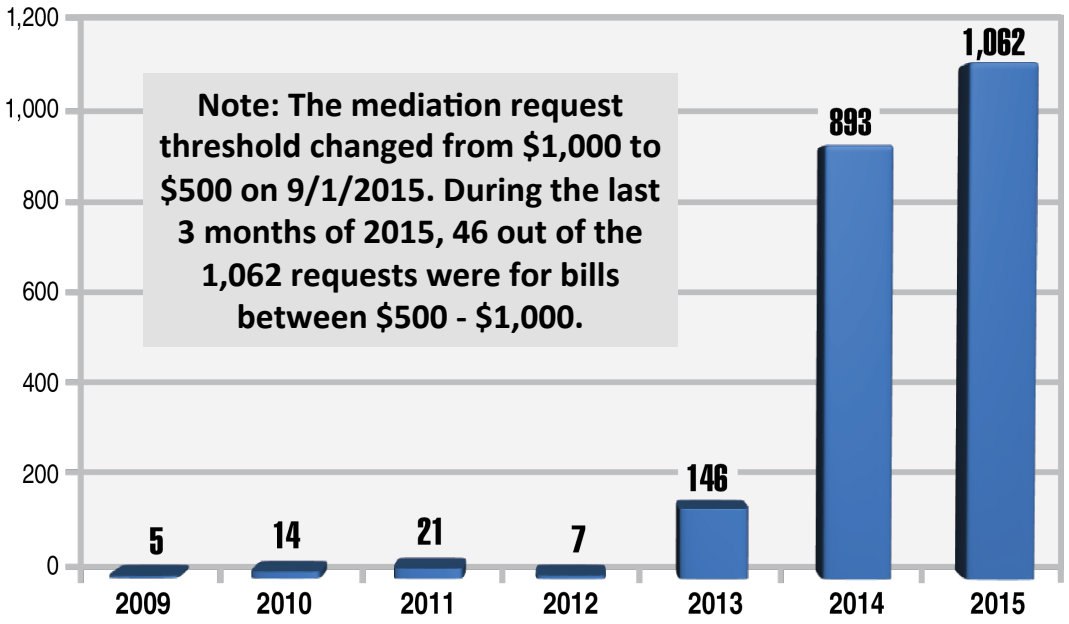
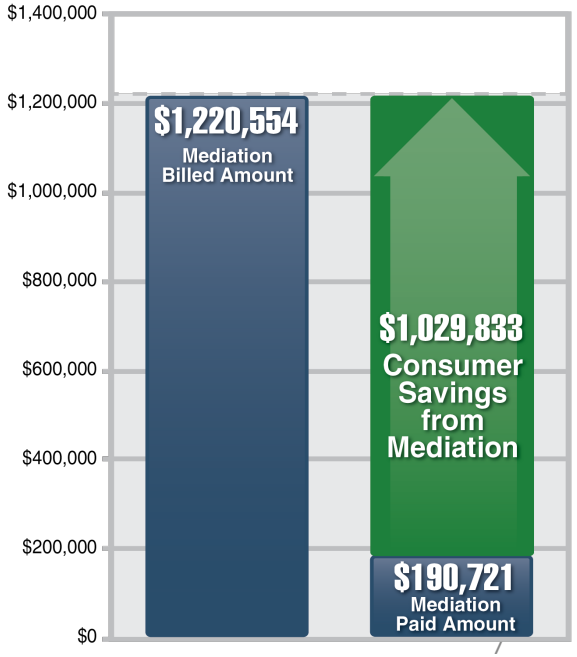
Mediation is Working When Available

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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Balance Billing is Still a Problem

- **Additional Hospital Based Providers:** Not all hospital-based providers are listed in statute - Surprise billing increasing from out-of-network "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 incentivize emergency care providers to stay out of network and inflate billed charges as a business model (Freestanding ERs, Large ER Physician Groups)
  - Balance billing protections vary across product types, creating confusion
- **Transparency:** System is still too confusing for consumers, providers are not required to be transparent about network status or prices

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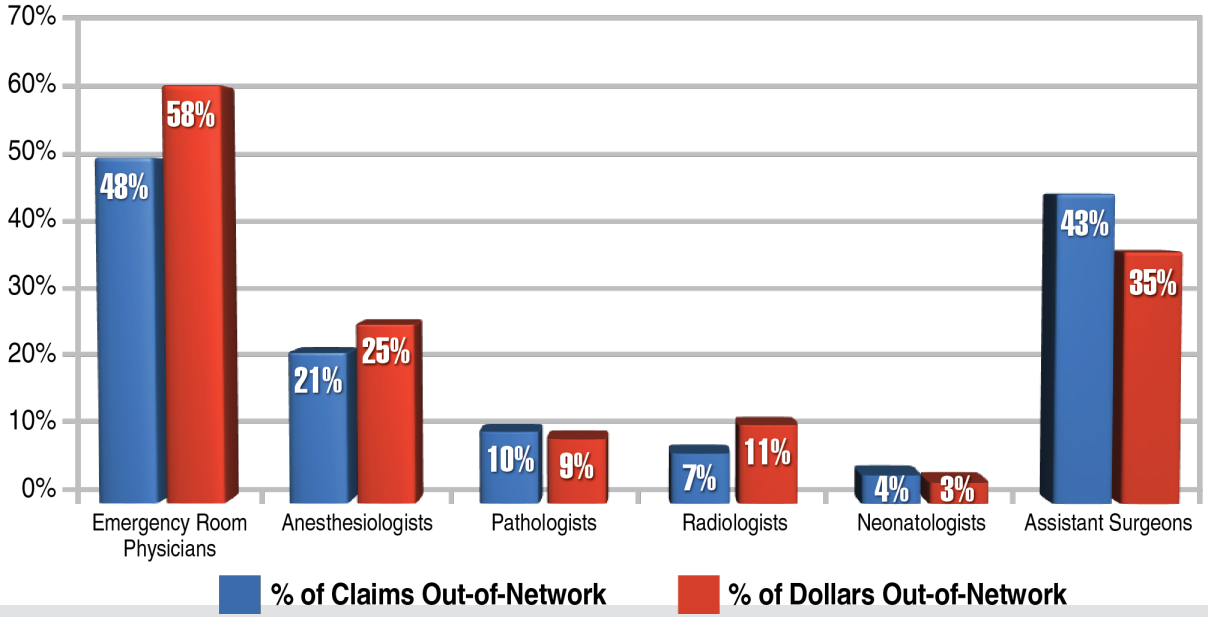
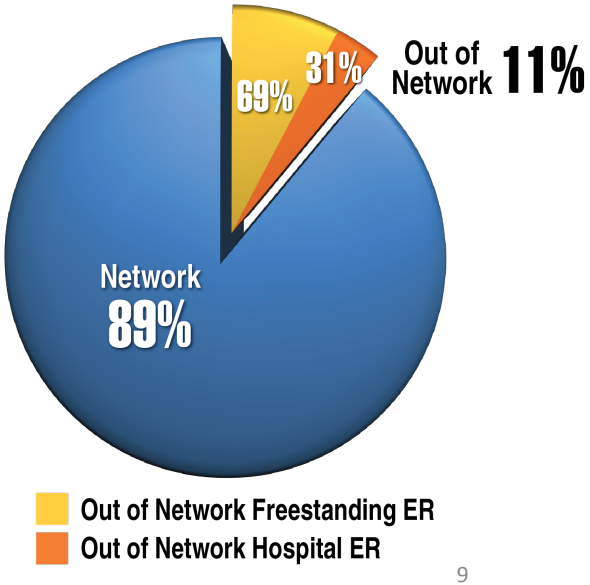
Emergency Services Are Still A Problem: 2015

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 Protections: Concerns

- **Emergency care 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 & inflate billed charges
  - 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 in excess of the "usual or customary charge"**
- **Consumers can still receive a balance bill in certain out-of-network ER situations**
- **Freestanding ERs tend to be out of network and confused with urgent care facilities**

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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	• 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	• 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	• In-Network Benefit Level (co-insurance percentage ex. 80/20)	• No Additional Federal Balance Billing Protection

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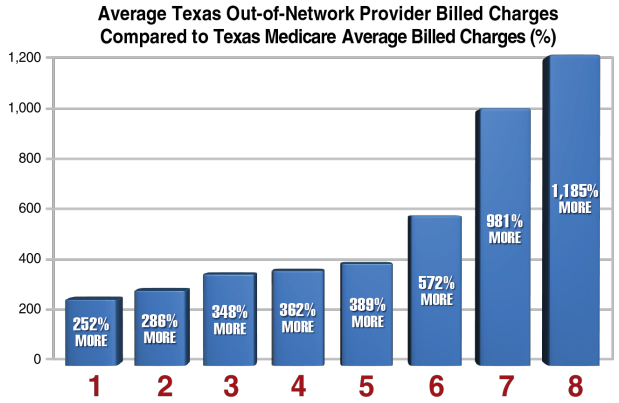
Problems with Billed Charges

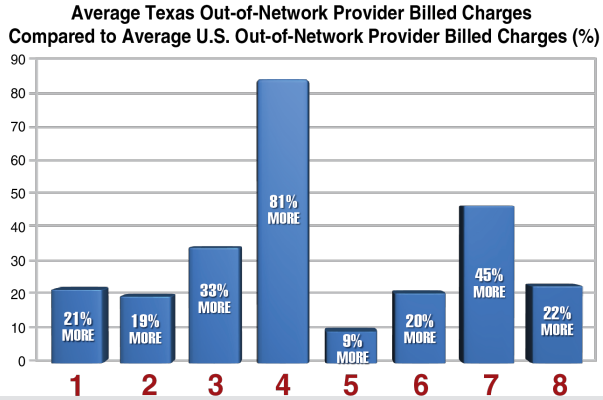
- No limit to what a provider can charge
- Self-determined
- Very little connection to underlying costs, quality, or market prices
- Huge variability
- Tying out-of-network rates to billed charges is an incentive:
  - to inflate billed charge
  - to stay out of network as a business model

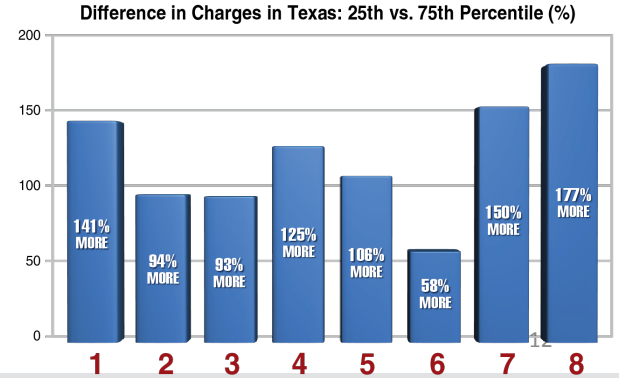
Out-of-Network Provider Billed Charges in Texas

Care Provided

1. Critical Care 1st Hour
2. Tissue Exam by Pathologist
3. Chemotherapy IV Infusion 1 Hour
4. Injection Therapy of Veins
5. Intensity Modulated Radiation Therapy
6. Emergency Department High Severity
7. MRI of Brain
8. Cervical/Thoracic Spine Injection







Source: Charges Billed by Out-of-Network Providers: Implications for Affordability

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Recommendations

- Expand mediation protection for consumers who receive services from other out-of-network providers providing working at an in-network hospital not currently listed in statute (Hospitalists, Nurse Anesthetists)
- Expand mediation to bills lower than the current $500 threshold
- Expand mediation and surprise billing protections for consumers for all out-of-network emergency care services – providers and facilities
- Streamline emergency care protections, so they are uniform across all product types and do not create an incentive for providers to stay out of network and inflate billed charges (Freestanding ERs, Large ER Physician Groups)
- Increase transparency of health care prices and network status

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

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Understanding Balance Billing: Two patients with sprained ankles 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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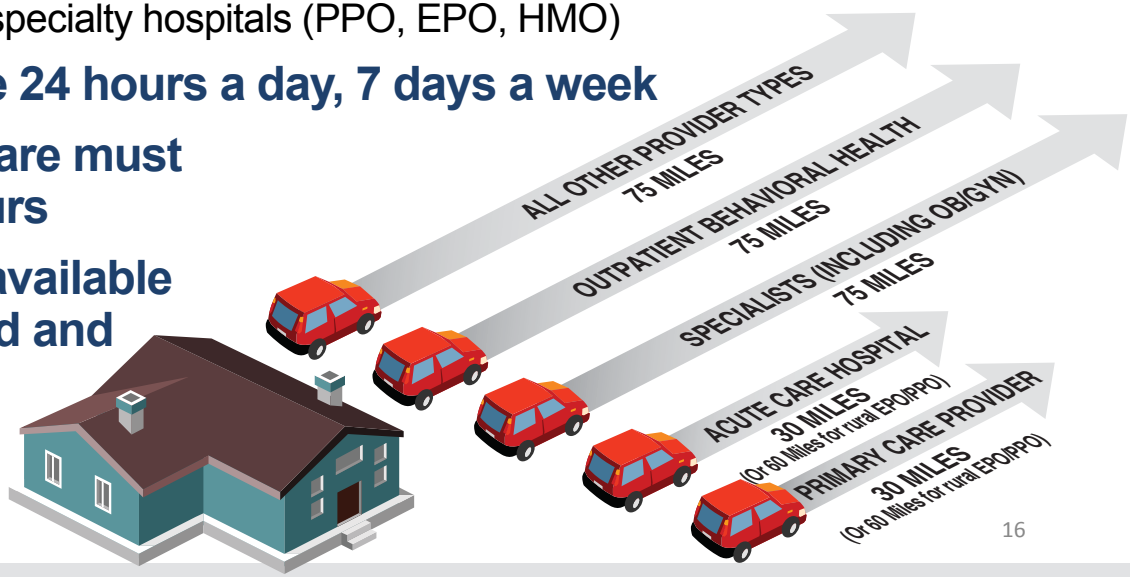
Network Adequacy Requirements

- **Maximum distance from any point in a health plan's service area:**
  - 30 miles for primary care and 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)
- **ER care must be available 24 hours a day, 7 days a week**
- **Non-emergency, urgent care must be available within 24 hours**
- **Preventive care must be available within 2 months for a child and 3 months for adults**



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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

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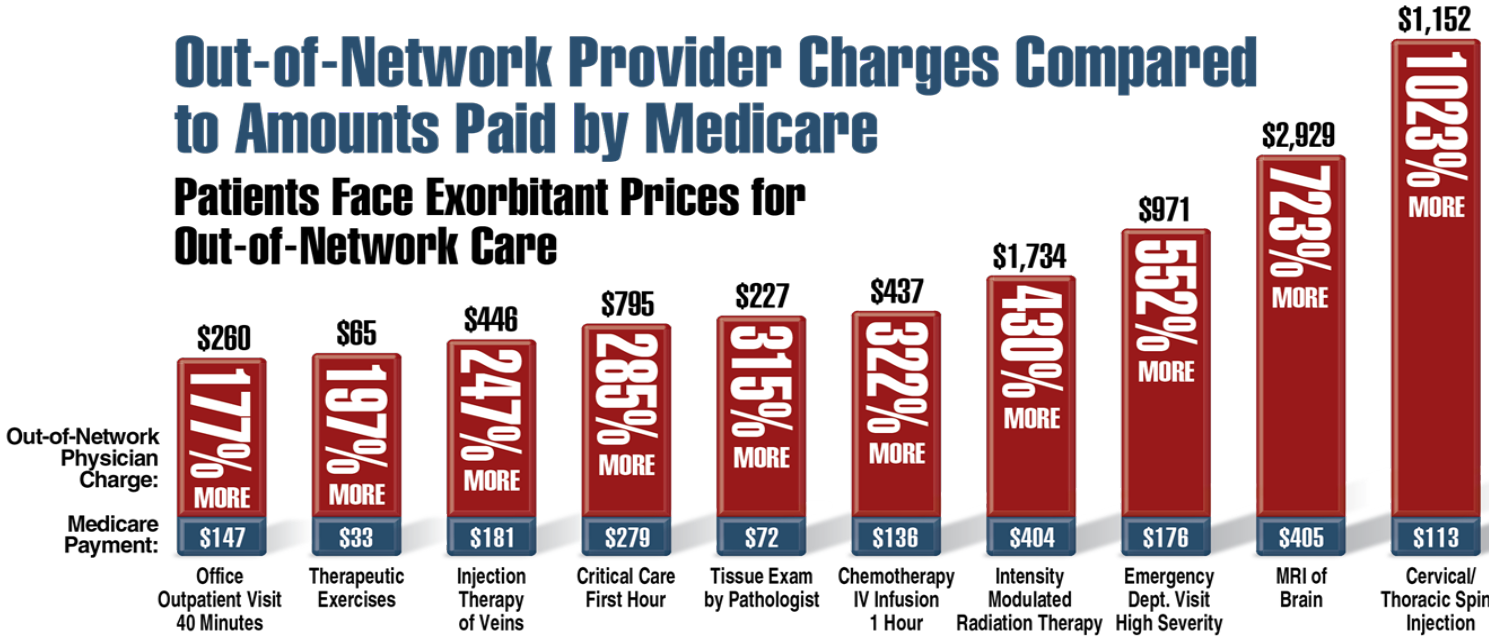
Out-of-Network Provider Charges Compared to Amounts Paid by Medicare

Patients Face Exorbitant Prices for Out-of-Network Care



Average Out-of-Network Billed Charges Were up to *1023%* the Amount Paid by Medicare.

(This graphic comparison is not to actual scale as the difference would be difficult to interpret on a single page.)

Source: America's Health Insurance Plans, "Charges Billed by Out-of-Network Providers: Implications for Affordability." September, 2015.

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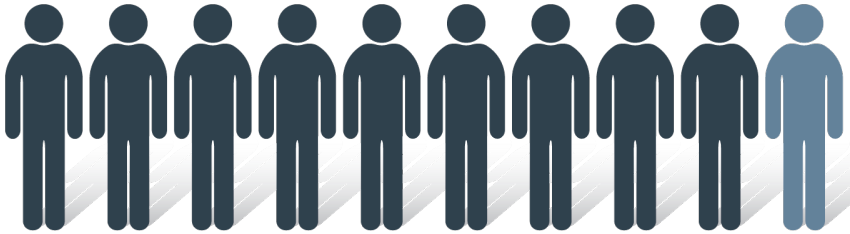
Consumer Health Plan Network Trends

- Consumers are satisfied with their health plan, cost, and their provider network (71% satisfied with plan, 61% said their coverage was excellent or good given cost)
  - 88% of consumers satisfied with the selection of providers from their health plan
  - Only 12% have had to change MD in last 12 months (50% stated it was not a problem)



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

Source: Kaiser Health Tracking Poll January 2016

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Freestanding ERs Charge Facility Fees

A patient with back pain chooses between a freestanding ER or urgent care center to receive in-network care.

VS

FREESTANDING ER CHARGES	SERVICE DESCRIPTION	URGENT CARE CENTER CHARGES
$895	Facility Charge—Level 3	$0
$53	Pulse Ox, Single	$0 (Included in physician charge)
$96	Pharmaceuticals (Toradol 15mg)	$40
$83	Intramuscular Injection (IM/SQ)	$28
$298	Physician Evaluation and Management	$150
$1,425	$ TOTAL BILLED CHARGES	$218
$1,196 Contract Rate	$ Insurance Benefit (Consumer has not met deductible)	$125 Contract Rate $25 Co-pay
$1,196 Paid by Consumer	$ TOTAL	$150 Paid by Consumer

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Example of Freestanding ER Website Notification

FIRST CHOICE EMERGENCY ROOM

THE NATION'S OLDEST AND LARGEST FREESTANDING EMERGENCY ROOM SYSTEM.

INSURANCE: HOUSTON/AUSTIN/SAN ANTONIO

First Choice Emergency Room is a free-standing emergency room. We function just like a hospital based emergency room. We will accept your ER co-pay at the time of service, and emergency room claims will be submitted to your insurance carrier.

We are not currently contracted with your insurance company. However, in the state of Texas, all emergency visits are to be processed as in-network regardless of the network status. What that means is your visit will be processed under your in-network benefits. Your insurance may not process it correctly the first time but our patient accounts department will work with them to have your claims reprocessed until they are processed under your in-network emergency room benefits. We accept all major, commercial insurance carriers like, but not limited to, AETNA, BCBS, Cigna, Humana, and United Healthcare.

If you have specific questions about your bill, please call our patient accounts team at the appropriate phone number below, weekdays between 8am and 5pm.

Houston/Austin/San Antonio (844) 564-2177

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Example of Freestanding ER Website Notification

+ HOW IS NEC DIFFERENT FROM TRADITIONAL HOSPITAL EMERGENCY ROOMS?
+ WHAT IF I HAVE QUESTIONS ABOUT MY BILL?
− WHAT INSURANCE DO YOU TAKE?

A: We accept all major private insurance plans like Aetna, Blue Cross/Blue Shield, United Healthcare, Humana, and others. If you do not have insurance, we'll work with you on a cash fee schedule to help you cover your visit. You'll never encounter hidden costs or surprise fees.

− WHAT IF YOU ARE NOT IN MY INSURANCE NETWORK?

A: According to Texas Guidelines, all insurance carriers are required to pay in-network benefits for any member presenting for emergency medical treatment. In fact, it's the law that you must be reimbursed by your insurance carrier for your emergency room visit. Texas law requires your insurance carrier to pay for your emergency care, whether the emergency room is "in network" or "out of network." The state of Texas empowers you to use "a prudent layperson standard" in considering what constitutes an emergency.