Surprise! A Look at the Hottest Topic in Health Care 2020:
NETWORK ADEQUACY AND SURPRISE BILLING
January 14, 2020
Health Law Section
Panelists

DAVID H. ELLENBOGEN, JD
Secretary & General Counsel
Scott & White Health Plan
David.Ellenbogen@BSWHealth.org

BRIAN E. HOYT, MBA
Managing Director
BRG
bhoyt@thinkbrg.com

CHRISTIAN PUFF (MODERATOR)
Assistant General Counsel
Parkland Community Health Plan
CHRISTIAN.PUFF@phhs.org

KENNETH WHITE, JD
NA Managed Care Practice and COE Leader
Willis Towers Watson
Kenneth.White@WillisTowersWatson.com

JEFF WURZBURG
Senior Counsel
Norton Rose Fulbright US LLP
jeff.wurzburg@nortonrosefulbright.com
Agenda

1. What Makes a Medical Bill Surprising?
2. What’s the Big Deal?
3. Provider Directories: The Cause or the Solution?
4. Federal Regulatory and Legislative Efforts
5. State Protections
What Makes a Medical Bill Surprising?
What Makes a Medical Bill Surprising?

- Arises when an insured patient inadvertently receives health care services from an out-of-network provider

- A patient is generally surprised in one or two ways:
  - Higher cost-sharing for out-of-network services
  - Provider may bill the patient directly for the “balance”
What Makes a Medical Bill Surprising?

- Hold patients harmless

- Payment resolution
  - Payment standard
  - Dispute resolution process
What’s the Big Deal?
What’s the Big Deal?

Google Trends

- surprise medical bills

United States  
1/1/10 - 1/6/20  
All categories  
Web Search

Interest over time

Jan 1, 2010  
Jan 1, 2013  
Jan 1, 2016  
Jan 1, 2019
What’s the Big Deal?

Among people with large employer coverage, the share of emergency visits with at least one out-of-network charge, 2017

States shaded gray have insufficient data

Source: KFF analysis of IBM Marketscan 2017 data
What’s the Big Deal?

Among people with large employer coverage, the share of in-network inpatient stays with at least one out-of-network charge, 2017

States shaded gray have insufficient data

Source: KFF analysis of IBM Marketscan 2017 data
What’s the Big Deal?

Prevalence of Admissions with Out-of-Network Professional Claims by State
Percent of In-Network Admissions with an OON Claim by State, 2016
What’s the Big Deal?

“Out-of-network billing by hospital-based specialists boosts spending by $40 billion”
What’s the Big Deal?

How worried, if at all, are you about being able to afford each of the following for you and your family?

- Very worried
- Somewhat worried
- Not too worried
- Not at all worried

<table>
<thead>
<tr>
<th>Issue</th>
<th>Very Worried</th>
<th>Somewhat Worried</th>
<th>Not Too Worried</th>
<th>Not at All Worried</th>
</tr>
</thead>
<tbody>
<tr>
<td>Unexpected medical bills</td>
<td>38%</td>
<td>29%</td>
<td>16%</td>
<td>16%</td>
</tr>
<tr>
<td>Health insurance deductible</td>
<td>24%</td>
<td>29%</td>
<td>20%</td>
<td>25%</td>
</tr>
<tr>
<td>Gas/transportation costs</td>
<td>20%</td>
<td>26%</td>
<td>25%</td>
<td>28%</td>
</tr>
<tr>
<td>Prescription drug costs</td>
<td>22%</td>
<td>23%</td>
<td>23%</td>
<td>31%</td>
</tr>
<tr>
<td>Utilities (electricity, heat)</td>
<td>19%</td>
<td>24%</td>
<td>27%</td>
<td>30%</td>
</tr>
<tr>
<td>Health insurance premium*</td>
<td>18%</td>
<td>24%</td>
<td>25%</td>
<td>32%</td>
</tr>
<tr>
<td>Rent or mortgage</td>
<td>22%</td>
<td>19%</td>
<td>21%</td>
<td>35%</td>
</tr>
<tr>
<td>Food</td>
<td>17%</td>
<td>20%</td>
<td>25%</td>
<td>38%</td>
</tr>
</tbody>
</table>

Note: “Not applicable” (N/A) and Don’t Know/Refused responses not shown. Question wording modified; see topline for full wording. *Among insured.

Source: KFF Health Tracking Poll (conducted August 23-28, 2018)

Health System Tracker
3

Provider Directories
Provider Directories: Cause or Solution?

Connection between surprise bills and the provider directory

Interest in improving patients’ access to directory data and information
Federal Regulatory and Legislative Efforts
The Federal Regulatory & Legislative Efforts

Network Adequacy: Quantitative Standards

**QUALIFIED HEALTH PLANS:** Issuers must maintain a network that is “sufficient in number and types of providers…to assures that all services will be accessible without unreasonable delay”.

- 45 C.F.R. § 156.230

**MEDICARE ADVANTAGE:** MAOs are required to “Maintain and monitor a network of appropriate providers that is supported by written agreements and is sufficient to provide adequate access to covered services to meet the needs of the population served. These providers are typically used in the network as primary care providers (PCPs), specialists, hospitals, skilled nursing facilities, home health agencies, ambulatory clinics, and other providers.”

- 42 C.F.R. § 422.112(a)(1)(i)

**MEDICAID MANAGED CARE**: “A State that contracts with an MCO, PIHP or PAHP to deliver Medicaid services must develop and enforce network adequacy standards…”

- 42 C.F.R. § 438.68(a)
- *CMS has proposed to relax state requirements. See 83 Fed. Reg. 572264, 57278 (Nov. 14, 2018).
### The Federal Regulatory & Legislative Efforts

**Network Adequacy: Quantitative Standards**

#### Example: Maximum Time and Distance

<table>
<thead>
<tr>
<th>Provider Specialty</th>
<th>METRO</th>
<th>MICRO</th>
<th>RURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Maximum Time (minutes)</td>
<td>Maximum Distance (miles)</td>
<td>Maximum Time (minutes)</td>
</tr>
<tr>
<td>Primary Care</td>
<td>15</td>
<td>10</td>
<td>30</td>
</tr>
<tr>
<td>Dermatology</td>
<td>45</td>
<td>30</td>
<td>60</td>
</tr>
<tr>
<td>Cardiology</td>
<td>30</td>
<td>20</td>
<td>50</td>
</tr>
</tbody>
</table>

#### Example: Minimum Provider Ratios

<table>
<thead>
<tr>
<th>Provider Specialty</th>
<th>METRO</th>
<th>MICRO</th>
<th>RURAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>Primary Care</td>
<td>1.67</td>
<td>1.42</td>
<td>1.42</td>
</tr>
<tr>
<td>Dermatology</td>
<td>0.16</td>
<td>0.14</td>
<td>0.14</td>
</tr>
<tr>
<td>Cardiology</td>
<td>0.27</td>
<td>0.23</td>
<td>0.23</td>
</tr>
</tbody>
</table>

**Network Adequacy: Provider Transitions**

<table>
<thead>
<tr>
<th>Standard</th>
<th>Timing</th>
<th>Requirement</th>
<th>Population</th>
<th>Regulation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medicare Advantage*</td>
<td>Good faith effort</td>
<td>30 days</td>
<td>Written notice primary care or seen on a regular basis</td>
<td>42 C.F.R. §422.111(e)</td>
</tr>
<tr>
<td>QHPs**</td>
<td>Good faith effort</td>
<td>30 days</td>
<td>Written notice/ Enrollees receiving primary care or seen on a regular basis</td>
<td>45 C.F.R. §156.230(d)</td>
</tr>
<tr>
<td>Medicaid</td>
<td>Good Faith Effort</td>
<td>Within 15 calendar days after receipt or issuance of termination notice</td>
<td>Written notice Enrollees receiving primary care or seen on a regular basis</td>
<td>42 C.F.R. §438.10(f)(1)</td>
</tr>
</tbody>
</table>

*Where provider is terminated without cause, an enrollee in an active course of treatment must be allowed to continue treatment until complete treatment or for 90 days

**MAO must notify the CMS Account Manager of significant no-cause terminations at least 90 days prior to the termination.
The Federal Regulatory & Legislative Efforts

**Network Adequacy: Network Breadth Pilot**

- CMS will continue the network breadth pilot for 2020
- Will display network breadth information on healthcare.gov in Maine, Ohio, Tennessee, and Texas
- Consumers will see information classifying the relative breadth of the plans’ provider networks, as compared to other Exchange plans in the county
- Three provider types:
  - adult primary care
  - pediatricians
  - hospitals
- Networks categorized as Standard, Broad, or Basic

The Federal Regulatory & Legislative Efforts

Medicare Advantage: Triennial Review

- Triennial Network Adequacy Review for Medicare Advantage Organizations and 1876 Cost Plans was approved by OMB on December 27, 2017.
- CMS will now review network compliance every three years, unless a triggering event occurs, including certain:
  › Initial Applications
  › Service Area Expansions
  › Significant Provider/Facility Contract Terminations
  › Access Complaints
  › Change-of-Ownership
  › Disclosed Network Deficiencies
- CMS will provide at least 60 days notice and MAOs must upload its network into the Network Management Module.
- Changes network adequacy to an operational requirement.
- Failing to meet NA requirements may lead to compliance or enforcement actions.
The Federal Regulatory & Legislative Efforts

Efforts to address Surprise Billing in 2019

February 2019 – Six US Senators send letter to health plans and hospitals asking for “additional data and more complete feedback in order to refine and inform our legislative proposal” related to surprise medical billing.
The Federal Regulatory & Legislative Efforts

Bipartisan letter sent to insurers and hospitals in February

As we continue our bipartisan effort to lower health care costs and improve price transparency, we seek more detailed information in addition to what we have received thus far. Surprise medical billing is a complex problem, and crafting bipartisan, effective legislation to address it will require greater engagement from the private sector. We want to protect patients from costly surprise bills while preventing undue disruption in the health care system. To meet this goal, it is critical that we receive additional data and more complete feedback in order to refine and inform our legislative proposal.

With this objective in mind, please send us the following information and data. In order to streamline the compilation of the information we receive, please respond in the following manner, to the extent possible:

- With specific state-by-state data, as applicable, for the following states that have a balance billing law in effect: Alaska, California, Colorado, Florida, Maryland, New York, and Texas.
- An average across remaining states, for those states without any existing balance billing law.

For questions pertaining to specific states, please feel free to return data in the manner specified in the questions themselves.

Source:
The Federal Regulatory & Legislative Efforts

<table>
<thead>
<tr>
<th>Scope of covered surprise bills</th>
<th>S 1895, reported by Senate HELP Committee</th>
<th>HR 2328, reported by House Energy and Commerce Committee</th>
<th>HR 3502, by Rep. Ruiz (D-CA) and 90 bipartisan cosponsors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Emergency services • Air Ambulance • Post-emergency Inpatient stabilization • Out-of-network provider services within in-network hospitals/facilities</td>
<td>• Emergency services • Post-emergency Inpatient stabilization • Out-of-network provider services within in-network hospitals/facilities</td>
<td>• Emergency services • Out-of-network provider services within in-network hospitals/facilities</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Patient held harmless</th>
<th>S 1895, reported by Senate HELP Committee</th>
<th>HR 2328, reported by House Energy and Commerce Committee</th>
<th>HR 3502, by Rep. Ruiz (D-CA) and 90 bipartisan cosponsors</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Plan must cover surprise bill as though in-network • Provider may not charge patient more than in-network cost sharing amount</td>
<td>• Plan must cover surprise bill as though in-network • Provider may not charge patient more than in-network cost sharing amount</td>
<td>• Plan must cover surprise bill as though in-network • Provider may not charge patient more than in-network cost sharing amount</td>
<td></td>
</tr>
</tbody>
</table>

Resolving payment for surprise bills

<table>
<thead>
<tr>
<th>Default payment amount</th>
<th>S 1895, reported by Senate HELP Committee</th>
<th>HR 2328, reported by House Energy and Commerce Committee</th>
<th>HR 3502, by Rep. Ruiz (D-CA) and 90 bipartisan cosponsors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Health plan’s median in-network payment rate</td>
<td>Health plan’s median in-network payment rate</td>
<td>Health plan’s median in-network payment rate in 2021, indexed to CPI-U in subsequent years</td>
<td>No provision</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Establish IDR process?</th>
<th>S 1895, reported by Senate HELP Committee</th>
<th>HR 2328, reported by House Energy and Commerce Committee</th>
<th>HR 3502, by Rep. Ruiz (D-CA) and 90 bipartisan cosponsors</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Factors considered at IDR</th>
<th>S 1895, reported by Senate HELP Committee</th>
<th>HR 2328, reported by House Energy and Commerce Committee</th>
<th>HR 3502, by Rep. Ruiz (D-CA) and 90 bipartisan cosponsors</th>
</tr>
</thead>
<tbody>
<tr>
<td>n/a</td>
<td>• Median in-network payment by other plans • Other factors (such as severity of case, provider training, etc.) • Provider’s billed charge may not be taken into account</td>
<td>• Median in-network payment by other plans • Other factors (such as severity of case, provider training, etc.) • 80th percentile of provider billed charges</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>CBO cost estimate</th>
<th>S 1895, reported by Senate HELP Committee</th>
<th>HR 2328, reported by House Energy and Commerce Committee</th>
<th>HR 3502, by Rep. Ruiz (D-CA) and 90 bipartisan cosponsors</th>
</tr>
</thead>
<tbody>
<tr>
<td>$24.9 billion savings over 10 years</td>
<td>$21.0 billion savings over 10 years</td>
<td>“double digit billions” in added federal costs over 10 years</td>
<td></td>
</tr>
</tbody>
</table>

Get the data • PNG
5 State Protections
State Protections

State balance billing protections for state-regulated plans

- Limited approach
- Comprehensive approach
- Comprehensive approach passed

Note: Four states have passed comprehensive protections that have not yet gone into effect as of June 2019

## State Protections

<table>
<thead>
<tr>
<th>CA</th>
<th>CO</th>
<th>OR</th>
</tr>
</thead>
<tbody>
<tr>
<td>TX</td>
<td>FL</td>
<td>NY</td>
</tr>
</tbody>
</table>
CALIFORNIA

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees*
  - For (1) emergency services* and (2) non-emergency services provided by out-of-network providers at in-network facilities
  - Provided by all or most classes of health care providers
- State provides a reimbursement payment standard**

State Protections

COLORADO

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing*
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing*
- Above protections apply
  - To HMO and PPO enrollees
  - For (1) emergency services and (2) non-emergency services provided by out-of-network providers at in-network facilities
  - Provided by all or most classes of health care providers
- State provides a payment standard**

State Protections

OREGON
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protection applies:
  - To HMO and PPO enrollees
  - For (1) emergency services provided by out-of-network providers at in-network facilities, and (2) non-emergency services provided by out-of-network providers at in-network facilities
  - Provided by all or most classes of health care providers
- State provides a payment standard*

TEXAS

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing*
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing*
- Above protections apply:
  - To HMO, PPO, and EPO enrollees*
  - For (1) emergency services, and (2) non-emergency services provided by out-of-network providers at in-network facilities*
  - Provided by all or most classes of health care providers
- State provides dispute resolution process**

FLORIDA

- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing
- Above protections apply:
  - To HMO and PPO enrollees
  - For (1) emergency services and (2) non-emergency services provided by out-of-network providers at in-network facilities
  - Provided by all or most classes of health care providers
- For PPOs, state payment standard applies to (1) emergency services and (2) non-emergency services provided by out-of-network providers at in-network facilities*
- For HMOs, state payment standard only applies to emergency services* but the state also has a claim dispute resolution program in place

State Protections

NEW YORK
- State requires insurers to hold enrollees harmless for amounts beyond in-network level of cost sharing
- State prohibits out-of-network providers from billing enrollees for any amount beyond in-network level of cost sharing*
- Above protections apply:
  - To HMO, PPO and EPO enrollees
  - For (1) emergency services, and (2) non-emergency services provided by out-of-network providers at in-network facilities
  - Provided by all or most classes of health care providers
- State provides a dispute resolution process**


* This protection applies to enrollees for services provided by out-of-network providers at in-network facilities.

** State provides a dispute resolution process for enrollees who are charged amounts beyond the in-network level of cost sharing.
6

Q & A
Thank You

DAVID H. ELLENBOGEN, JD
David.Ellenbogen@BSWHealth.org

BRIAN E. HOYT, MBA
bhoyt@thinkbrg.com

CHRISTIAN PUFF (MODERATOR)
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