An Analysis of Policy Options for Involuntary Out-of-Network Charges in New Jersey

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Prepared by:
Avalere Health LLC

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EXECUTIVE SUMMARY

Health plans maintain networks of hospitals and physicians as a way to control costs and promote high-value patient-centered care. New Jersey's insurance regulations, while designed to protect consumers when receiving involuntary care from out-of-network (OON) providers, may undermine these goals.

New Jersey's "hold harmless" rules protect consumers in an emergency or when they receive care from a physician whose network status is difficult to discern by limiting cost sharing to the amount a consumer would pay an in-network provider. They also require health plans to pay OON providers up to their charges to ensure providers do not balance bill their patients. Since New Jersey does not regulate how much OON providers can charge, the rules thereby permit OON providers to charge amounts that, at times, are excessive. Health plans must then incorporate these costs into the insurance premiums that consumers and businesses pay. Research indicates that New Jersey health insurance premiums and charges by providers are among the highest in the nation: Premiums in the state have grown by 71% since 2003[1] and New Jersey hospitals on average charge 630% of what Medicare pays.[2] In addition, health plans operating in New Jersey estimate that the impact of the "hold harmless" rules is in the many millions of dollars each year in the form of higher premiums, and that reforming the "hold harmless" rules by regulating OON charges could lead to premium and out-of-pocket savings for consumers.[3]

This brief examines the current New Jersey rules and the state's healthcare cost environment. It provides a comparative review of how select states limit the impact of involuntary OON charges on both cost sharing and premiums. Finally, it assesses several potential policy responses for reform in New Jersey. Policy responses could take the form of a balance billing ban to protect consumers, in combination with a payment benchmark for emergency and involuntary OON services and/or an arbitration approach to settle disputes between health plans and providers. The state legislature in New Jersey is expected to consider changes to its current rules during the 2015 legislative session.[4]

INTRODUCTION

Federal and state policymakers are grappling with how to ensure access to affordable healthcare for consumers across insurance marketplaces. While the Affordable Care Act (ACA) established some new protections for consumers and a regulatory floor for individual and small group health insurance benefit design, structure, rating,[5] and cost sharing, federal rules do not prohibit balance billing in any commercial insurance markets, meaning a provider may bill consumers for the portion of charges not covered by their health plan. Limiting an insured person's financial liability for care is one way policymakers can help ensure access.

Unfortunately, balance billing can leave consumers with significant bills, especially during a medical emergency or when a patient is unknowingly seen by an OON provider during a procedure at an in-network facility (involuntary OON utilization). New Jersey and other states have taken action to protect consumers from balance billing in these involuntary care situations. While New Jersey does not prohibit balance billing, it does require health plans to hold their members financially harmless from any OON cost sharing that exceeds in-network levels for emergency services or involuntary OON utilization. The state legislature in New Jersey is expected to consider changes to its current rules during the 2015 legislative session.[6]

NEW JERSEY'S HEALTHCARE COST ENVIRONMENT

The New Jersey healthcare marketplace has some of the highest health insurance premiums and provider charges in the nation. A Commonwealth Fund analysis found that New Jersey premiums in the employer market rank in the top four nationally with an average of $17,396 for family coverage in 2013.[7] Family coverage premiums have increased by 71% since 2003. The growth has accelerated in the last three years, averaging 7.1% annually from 2010-2013. While 31 other states have experienced slowdowns in the rate of premium growth since 2010, New Jersey's premium growth remains high relative to the nation.

In addition, New Jersey hospitals are some of the most expensive in the country.[8] Acute care hospitals in New Jersey have the highest Medicare charge to payment ratio of any state, with an average charge that is 630% of Medicare payment rates, compared with a national average charge that is 390% of Medicare.[9]

NEW JERSEY'S RULES FOR OUT-OF-NETWORK PROVIDERS

When consumers in New Jersey receive care from OON providers whom they have no ability to choose or avoid, the New Jersey Department of Banking and Insurance (DOBI) rules[10] partially protect insured patients by requiring plans to limit consumer financial responsibility to the in-network copayment, coinsurance, or deductible amount. These rules require that coverage be provided to consumers for OON services at in-network benefit levels for:

1. Emergency services rendered by out-of-network providers, including ambulances;[11]
2. When a patient receives treatment at an in-network facility by an OON specialist (e.g., anesthesiologist or surgeons) or other OON providers;[12] and
3. When a health plan member tries to choose an in-network facility or provider but access is limited, so they must choose, or be referred by their plan to, an OON provider.[13]

Since enrollees cannot be billed more than the in-network level for the services rendered and plans must protect the members from balance billing, health plans find themselves in the position of paying billed charges or litigating over billed charges in order to hold the enrollee harmless. A mediation process currently exists in New Jersey where insurers and providers can seek to resolve billing disputes, but it is voluntary and unclear how frequently the process is used.

Legally, these DOBI rules apply only to fully insured health maintenance organizations (HMOs) and other non-HMO network based plans sold to individuals or employers. However, many self-insured employers follow the same OON rules.

OON CHARGES IN NEW JERSEY

Cost and Premium Impacts

According to an actuarial study commissioned by Horizon Blue Cross Blue Shield of New Jersey (BCBSNJ), and figures released publicly by Aetna, OON charges can be significant drivers of insurer costs and thereby impact the premiums paid by consumers in New Jersey. In a 2015 study by Victoria Boyarsky and Bruce Pyenson, paid OON claims comprised 8% of Horizon BCBSNJ's 2013 commercial spending. The authors found that if Horizon paid OON physician claims at 150% of the Medicare rate instead of up to the full charged amount, across all commercial plans, Horizon would pay 52% less for OON physician services.[14] This is equivalent to a savings of $497 million, or a 4.3% reduction in total commercial paid claims.[15] Although premium pricing is based on a host of factors,

it is likely that a reduction in paid claims would result in some level of premium savings for consumers. The study also showed that consumers could pay 9.5% less out of their pockets in the form of cost sharing with OON allowed rates set at 150% of Medicare rates.[16]

Aetna has linked high OON bills at select New Jersey for-profit hospitals to higher insurance premiums for its 1.1 million customers statewide. Aetna estimated that over the last three years, these hospitals, after turning a profit and exiting their networks, have driven up costs for Aetna's members by $15 million.[17]

Since few states have OON "hold harmless" rules similar to New Jersey, the literature examining this issue in other states is limited. However, two studies suggest a link between limiting OON charges and lower premiums. An analysis[18] of a California proposal to limit plan liability for OON charges found that limiting OON charges can modestly reduce premiums for consumers in a state. Additionally, in a report on the impacts of "surprise bills" and health plan responses, the New York State Department of Financial Services found that health plans that began using a fee schedule for their OON charges, the majority of which used Medicare as the benchmark, reported varied premium savings for consumers.[19]

Stakeholder Perspectives

A wide variety of New Jersey stakeholders, including consumers, health plans, businesses, and providers, have expressed concern around the issue of payment for OON charges and the impact it may have on premium growth in the state.

In testimony before the New Jersey Assembly Financial Institutions and Insurance Committee, the New Jersey Appleseed Public Interest Law Center brought attention to the issues around OON charges and increases in premiums.[20] The organization noted that the problem is three-fold for consumers: Select OON providers are promoting admission to emergency rooms, consumers are subject to surprise bills from an OON physician at an in-network facility, and finally there is the problem of inadequate provider networks. They noted that "all three [issues] require at minimum complete transparency and disclosure by providers and insurers so as to enable consumers to make better decisions, protect themselves from unexpected bills…and to understand both the immediate and long-term consequences for cost."

Likewise, small businesses have expressed concern. The New Jersey Business & Industry Association (NJBIA) noted that "These [out-of-network healthcare costs] play an increasingly important role in the rising cost of health care for small employers in New Jersey, triggering both higher premiums and out-of-pocket expenses."[21]

Health plans have taken an active approach to this issue. A variety of groups, including America's Health Insurance Plans (AHIP), have consistently pointed to the issue of OON charges as deserving attention and reform.[22] The New Jersey Association of Health Plans, testifying before the New Jersey Assembly Financial Institutions and Insurance Committee, noted that "Price gouging has a direct impact on premium cost."[23]

Finally, concerns have also been expressed by some providers. In fact, the New Jersey Hospital Association in an issue brief wrote, "As the debate continues to grow over controlling rising out-of-network costs within our healthcare system, it is apparent that reform is needed."[24]

INVOLUNTARY OON RULES: FEDERAL AND STATE COMPARISONS FOR NEW JERSEY

Federal Rule Established by the Affordable Care Act (ACA)

The ACA does not address involuntary OON payments except in the context of emergency services. While federal law prohibits commercial market plans from requiring cost sharing for OON emergency services greater than would apply if the provider were in network, it does not prohibit an emergency services provider from balance billing the plan member after a plan has reimbursed a provider the greater of:[25]

1. The median amount the plan pays in-network providers for the emergency service;
2. The amount for the emergency service calculated using the same method the plan generally uses to determine payments for out-of-network services (such as the usual, customary, and reasonable amount); or
3. The amount that would be paid under Medicare.[26]

Involuntary OON Rules in Other States

As New Jersey considers new rules regarding OON charges, the state can inform its policy development by examining other states' experiences. In addition to New Jersey, 12 states to some degree limit HMO members' liability for involuntary OON charges (8 of those extend some form of protections to PPO enrollees).[27] However, the protections vary depending on the service, with the majority of the protections focusing only on emergency services. Unlike New Jersey, most of the other states that have elected to address the issue have also selected a mechanism to regulate the payment dynamic between the health plan and the provider, and thereby limit the impact of OON charges on premiums. Currently, New Jersey stands alone among states in requiring non-HMO plans to pay up to the OON charges in emergency services.

While the current New Jersey rules offer financial protection to consumers, these rules do not limit what OON providers can charge and, therefore, create a financial incentive for providers not to join, or to drop out of healthcare networks, and to levy higher charges.[28] In turn, many parties in the state of New Jersey, including health plans, business groups, and employers, believe that these rules drive up insurance premiums, since health plans ultimately must build any payments made for OON charges into rates.

The chart below highlights those states that protect patients in terms of cost sharing which also address payments that plans make to providers for involuntary OON care, including payment schedules and binding arbitration.

State	Protections for OON Emergency Services	Protections for OON Providers at Inpatient Facility	Plan Type	Health Plan Payment Requirements
New Jersey	**Yes**	**Yes**	**HMOs, PPOs**	**Health plan pays the provider's charges**
California[29, 30]	Yes	No	HMOs	Health plan pays provider a "reasonable payment"
Colorado[31]	No	Yes	HMOs, PPOs	Health plan pays the provider's charges
Delaware[32, 33, 34]	Yes	No	HMOs	Health plan pays first the highest allowed amount by the carrier in last 12 months, followed by binding arbitration if provider does not find the payment sufficient
Florida[35, 36, 37]	Yes	No	HMOs	Health plan pays provider the lesser of charges, usual and customary provider charges for similar services, or mutually agreed amount within 60 days of claim
Illinois[38]	No	Yes	HMOs	Health plan pays in-network rates to OON providers at in-network facility, subject to arbitration if provider disagrees
Maryland[39, 40]	Yes	Yes	HMOs, PPOs	Health plan pays OON provider a percentage (above 100%) of the state provider fee schedule
New York[41]	Yes	Yes	HMOs, PPOs	Health plan and provider subject to binding arbitration

EXAMINING POLICY OPTIONS FOR NEW JERSEY

Other states protect consumers from the full impact of involuntary OON charges by some combination of explicitly banning the practice of balance billing to hold consumers harmless and applying two general approaches for settling reimbursement disputes between plans and providers—payment benchmarks and arbitration.

Payment Benchmark Options

A payment benchmark approach would use a formula based on a real-world measure (e.g., a fee schedule, in-network rates, or Medicare rates) to determine how much a health plan would pay an OON provider. Benchmark options would all limit reimbursement in some way, providing predictability for plans, providers, and consumers, as well as minimizing transaction costs for all parties. In addition, a payment benchmark approach brings transparency to an area of healthcare where consumers, employers, and regulators typically have had very little visibility. Premium savings for consumers and employers should derive from lower payment rates associated with these benchmark options.

The following table highlights the advantages and disadvantages of three potential benchmark options. In general, setting OON rates to a certain percentage of Medicare rates would be less complicated than the other two options, but the other two options would have the benefit of better reflecting commercial market conditions. All three benchmark options would generally be more predictable and efficient than the arbitration options discussed below.

Policy Options	Advantages	Disadvantages
1. Set OON charges to a certain percentage above a health plan's or provider's average in-network rate	• Should ensure OON providers, who do not receive the volume benefits that come with being in network, receive more than the plan's average in-network rate • Honors confidentiality of health plan/provider contracting by relying on average in-network rates	• Requires a regulatory function to collect and/or audit to ensure that rates are accurate • Health plans and providers may not have an in-network rate available for certain services • Providers will see different rates from every health plan depending on the health plan's average in-network rates, which may not reflect nuances of the provider's services
2. Set OON payment to a certain percentage of Medicare rates	• Does not require the creation of a new fee schedule • Health plans and providers are familiar with Medicare rates • Does not require health plans or providers to reveal proprietary contracting data • Does not provide incentive for providers to raise billed charges • Medicare rates may be lower than negotiated in-network rates, thus providing an incentive for the provider to join health plan networks	• Does not ensure that providers will receive more than their in-network rates • Medicare rates change every year based on trends that may not match the commercial market
3. Build a state-defined fee schedule for OON charges	• Transparency and predictability for health plans, providers, consumers, and employers • Fee schedule presumably built using a combination of actual commercial billed OON charges by providers and OON payments by health plans • Reduces administrative costs for health plans and providers associated with emergency and "surprise" OON visits	• Administratively complex for the state to create, update, and maintain • Potentially significant confidential data collection requirements from health plans and providers • Potentially significant administrative cost for plans and providers

Arbitration Options

Instead of using a benchmark, New Jersey could require a binding arbitration process, similar to New York's new law set to go into effect during the spring of 2015, to settle OON reimbursement disputes. While outcomes in particular cases could be more tailored than with a benchmark, the administrative and transaction costs may be higher, even in the most simple arbitration process. There are transparency concerns around arbitration rulings, and concerns about the qualifications and professional sympathies of the arbitrator. Additionally, there is potential that the first few arbitration decisions could create a de facto fee schedule that then influences all future rulings, potentially at the expense of the provider or the health plan.

Qualified arbitrators could be representatives of the state Department of Insurance, an industry representative familiar with rate-setting practices, or an academic arbitrator with appropriate educational qualifications and background knowledge. Selecting an impartial, knowledgeable arbitrator, along with establishing strict guidelines that yield fair and equitable awards, would be important to ensuring that the decisions reflect all the facts in the case without any measure of bias.

Policy Options	Advantages	Disadvantages
4. Final offer or "baseball style" arbitration	• Encourages both parties to submit reasonable offers • Provides a consistent dispute resolution process where the arbitrator selects one of the two offers submitted (either by the health plan or by the provider	• Administrative and transaction costs higher than in benchmark approaches above • Difficult to select an impartial and knowledgeable arbitrator • First few arbitration decisions may set a de facto fee schedule
5. Traditional arbitration	• Provides a consistent dispute resolution process where the arbitrator reviews the offers submitted by both parties and may provide a ruling that is a compromise of the two offers • Allows participants ample opportunity to support their case • Arbitrator has the option to choose a settlement between the parties, rather than selecting one offer	• Administrative and transaction costs are higher than final offer arbitration and benchmark approaches • Difficult to select an impartial and knowledgeable arbitrator • First few arbitration decisions may set a de facto fee schedule

CONCLUSION

Health plans build provider networks both to manage costs and to promote higher quality care for their members. These relationships are also critical building blocks needed to support evolving accountable and coordinated care structures that aim to promote and reward high-value patient-centered care rather than high-volume fee-for-service medicine. Current New Jersey rules that apply when health plan members involuntarily utilize OON providers, with no limit on what OON providers can charge, create an incentive structure that is at odds with these goals.

Instead of prohibiting balance billing, the rules protect consumers from excessive cost sharing at the point of care by requiring health plans to limit member financial responsibility to the in-network copayment, coinsurance, or deductible. This consumer protection is only partial, however, as the rules expose consumers, employers, and governments to higher insurance premiums after the fact by requiring health plans to reimburse a provider up to 100% of whatever is charged.

This paper outlines several reform options for New Jersey to consider regarding the issue of surprise OON charges that protect consumers, while setting up a regulatory structure to ensure health plans pay and OON providers receive fair payments. The reform options referenced in this paper could be used by New Jersey to level the regulatory playing field between plans and providers in regard to this targeted but important healthcare cost driver in the state.

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Contact Us

Avalere Health
1350 Connecticut Ave, NW Suite 900
Washington, DC 20036
202.207.1300 | Fax 202.467.4455
www.**avalere**.com