CENTER *for* PUBLIC POLICY PRIORITIES

Charge #2: Surprise medical billing and network adequacy

House Insurance Committee

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June 1, 2016

Surprise Medical Billing in Emergencies

Scope of the problem

- Nearly 7 in 10 of individuals with unaffordable out-of-network bills did not know the provider was not in their plan's network, at the time they received care [Kaiser Family Foundation survey].

- Over a two-year period, 33% of privately insured Texans received a bill where the plan paid much less than expected or nothing, including Texans who:
  - got a bill from a doctor they did not expect to get a bill from (35%) and/or;
  - were charged at an out-of-network rate when they thought the provider was in-network (20%) [2015 Texas Resident Survey, Consumer Reports National Research Center]

- Complaints to TDI about balance billing have increased 10-fold from 2012-2015.

Common scenarios for surprise billing from out-of-network care

Emergencies

Out-of-network care at in-network facilities

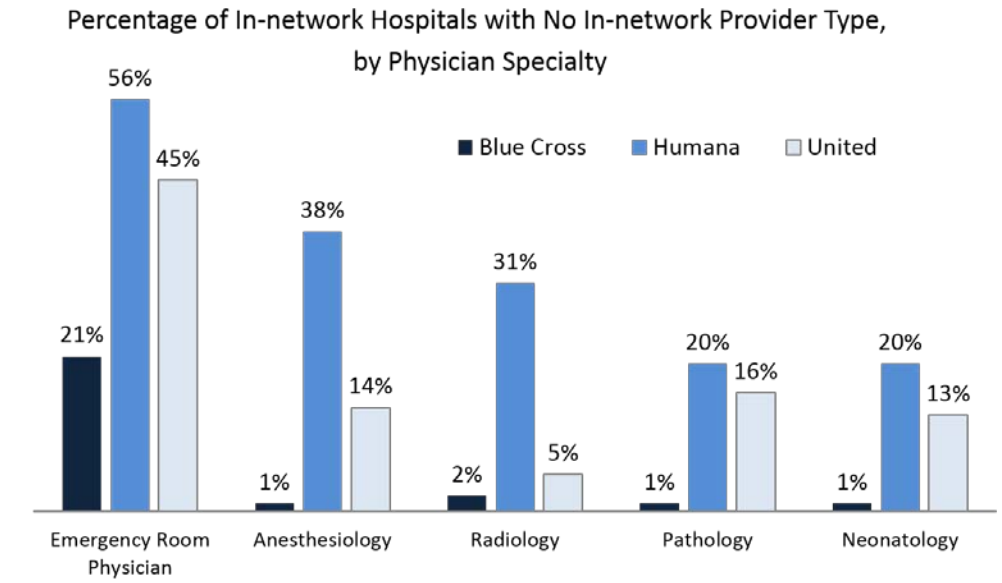
- Scheduled procedures
- Post-stabilization care

Consumers may also be balance billed if they make informed, voluntary use of out-of-network providers, but this does not constitute surprise billing

Why focus on emergency care?

In an emergency, patients can't pick their doctors or control which facility the ambulance goes to. They need to get to the closest emergency room.

Many In-network ERs Have No In-network ER doctors



CPPP analysis of data supplied by Texas' three largest health and accident insurers by market share. CPPP, "Surprise Medical Bills Take Advantage of Texans," September 15, 2014, http://forabettertexas.org/images/HC_2014_09_PP_BalanceBilling.pdf.

Protecting Texans from surprise emergency medical bills

- Texans should be protected from surprise bills from emergencies. Texans should be responsible for their deductibles and copayments, but not for unexpected charges beyond those amounts
- Texans recovering from emergencies should not have to jump over bureaucratic hurdles to address unexpected charges
- Providers and insurers should continue to use Texas' existing mediation process to reach a fair price
- All Texans with state-regulated insurance should be protected from surprise emergency medical bills, with no loopholes

Photo courtesy of AARP

Who is left out after an emergency today in Texas?

Patients are locked out if the closest emergency room was in an out-of-network hospital or a free-standing ER.

- Caitlin in Austin tried an urgent care clinic but was sent to the closest ER, which was out-of-network. She got a surprise bill for $12,300 following a CT scan, blood tests, fluids, and treatment for a reaction to medication

Patients are locked out if their bill is less than $500, even if they receive several surprise medical bills that add up to more than $500.

- Matt in Austin took his daughter to the ER when she was having trouble breathing. The hospital was in-network, but they received a $450 surprise bill from the out-of-network ER doctor.
- Sonya in Grapevine got a $348 surprise bill from and out-of-network ER doctor at an in-network ER.

Bills are ineligible for mediation if from a provider other than a radiologist, anesthesiologist, pathologist, emergency department physician, neonatologist, and assistant surgeon

- Terry in Richardson got a $992 surprise bill from ground ambulance in an emergency. The ambulance provider would not negotiate and turned the bill over to collections, hurting Terry's credit.

Patient stories courtesy of Consumers Union

Burdensome requirements in Texas keep ER patients from benefiting from mediation

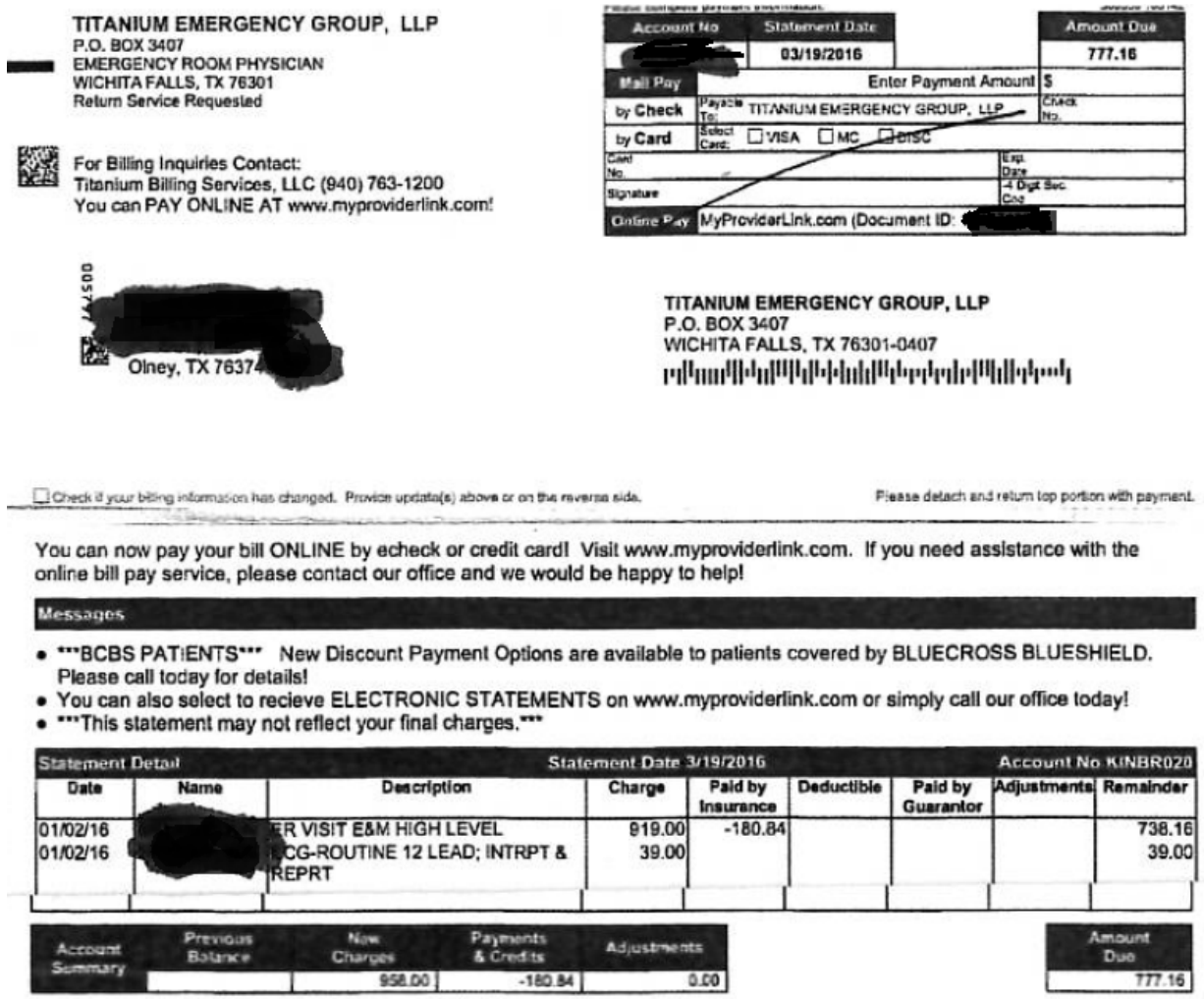
Burdens placed on patients:

- Must know you have a balance bill (not easy).
  Can you tell that the bill at the right is a balance bill?
- Must be aware of and understand mediation
- Must decode your bill to see if it is eligible
- Must fill out paperwork
- Must attend a pre-mediation teleconference

These burdens become barriers when:

- Patients are recovering from medical emergencies like strokes and heart attacks
- Patients receive many different bills after an ER trip

Limited use of mediation (2,150 requests in 7 years) may reflect unreasonable burdens placed on patients



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Account No	Statement Date	Amount Due
[redacted]	03/19/2016	777.16

Mail Pay — Enter Payment Amount $
by Check — Payable To: TITANIUM EMERGENCY GROUP, LLP — Check No.
by Card — Select Card: VISA MC DISC
Card No. — Exp. Date
Signature — 4 Digit Sec. Code
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Messages

- ***BCBS PATIENTS*** New Discount Payment Options are available to patients covered by BLUECROSS BLUESHIELD. Please call today for details!
- You can also select to recieve ELECTRONIC STATEMENTS on www.myproviderlink.com or simply call our office today!
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Statement Detail — Statement Date 3/19/2016 — Account No KINBR020

Date	Name	Description	Charge	Paid by Insurance	Deductible	Paid by Guarantor	Adjustments	Remainder
01/02/16	[redacted]	ER VISIT E&M HIGH LEVEL	919.00	-180.84				738.16
01/02/16		CG-ROUTINE 12 LEAD; INTRPT & REPRT	39.00					39.00

Account Summary	Previous Balance	New Charges	Payments & Credits	Adjustments	Amount Due
		958.00	-180.84	0.00	777.16

What do other states do?

- At least 10 states protect patients from surprise bills in emergencies (FL, IL, NY, CT, MD, NJ, CA, DE, PA, and CO)
- 3 of these states allow insurers and providers to work *directly* through dispute resolution to reach a price. (FL, IL, NY)
- 7 of these states extend bill protections to non-emergency surprise bills (FL, IL, NY, CT, MD, NJ, and CO)

FL and NY laws

Florida

- Protects patients from balance bills in emergencies and out-of-network care at an in-network hospital
- Patients responsible for in-network deductibles/copays
- Insurers and providers have access to dispute resolution process to determine payment rate
- Incentive for reasonable final offers before dispute resolution
- Hospital disclosure of in-network health plans
- Bill signed April 2016
- Support from consumers, insurers, and many medical groups

New York

- Protects patients from balance bills in emergencies and out-of-network care at an in-network facilities
- Patients responsible for in-network deductibles/copays
- Insurers and providers have access to dispute resolution process to determine payment rate
- Incentive for reasonable initial bills/payments, and loser pays for dispute resolution
- Increased disclosure from all parties
- Took effect March 31, 2015
- General support from range of stakeholders

Initial results from New York

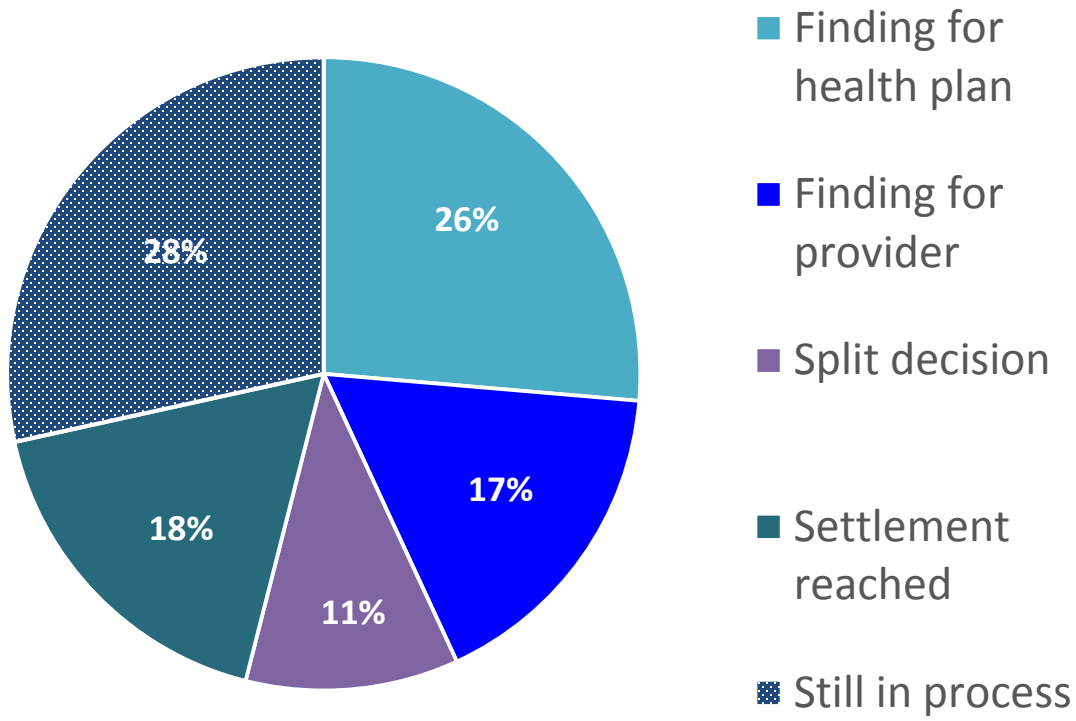
Of surprise bill dispute resolution requests filed from April 1, 2015 – February 29, 2016:

- 239 eligible requests filed
- 171 decisions rendered
- Findings split between doctors and insurers

Amounts of final resolutions when decided for provider or health plan:

- < $500: 15 cases
- $500 - $1K: 37 cases
- $1,000+: 52 cases

Arbitration decisions in NY split between plans and insurers
(of 239 eligible bills)



Data from New York State Department of Financial Services, analysis by CPPP

Network Transparency and Adequacy

Network adequacy key points

- Many areas of the state where most or all Marketplace networks are “narrow”
- Network size is used as a proxy for access, but may not always be a good one
- Meaningful access and quality matter more, but are harder to measure
- Marketplace shoppers, on average, are willing to trade network breadth to get lower premiums
- Nationwide, most Marketplace enrollees report satisfaction with networks
- Robust monitoring and oversight is essential
- More network transparency on the horizon, but more work is needed

Can consumers get the right care, in a timely manner, without having to travel unreasonably far?

Essential network adequacy components

Minimum quantitative time and distance standards:

- Regulatory floor needed. Even the narrowest networks must be adequate
- Texas' minimum standards are spare.
- Waivers may be appropriate in some circumstances other than primary and emergency care.

Rigorous oversight:

- Ongoing oversight is essential
- Regulators need good data on the network, changes to the network, local market of providers, use of out-of-network services, and consumer experiences trying to get care
- Sufficient regulatory capacity needed for meaningful oversight

Transparency and informed choices:

- Consumers should be provided with the information and tools needed to make informed choices:
  - Network breadth (improvements slated for 2017)
  - Quality and access measures for the network/plan
  - Provider directories that are complete and accurate
  - Access to waivers, network reports, access plan

Additional Information on Surprise Billing and Network Adequacy

State Protections from Surprise Medical Bills in PPOs

State	In Emergencies			Non-emergency
	Surprise bills banned	Consumers pay only deductibles, copayments, and coinsurance as if care was in-network	Insurers and providers work *directly* through dispute resolution to reach a fair price	Billing protections extended to non-ER care, where consumer gets out-of-network care involuntarily
Florida	**x**	**x**	**x**	**x**
Illinois	**x**	**x**	**x**	**x**
New York	**x**	**x**	**x**	**x**
Connecticut	**x**	**x**		**x**
Maryland	**x**	**x**		**x**
New Jersey	**x**	**x**		**x**
California	**x**	**x**		
Delaware	**x**	**x**		
Pennslyvania	**x**	**x**		
Colorado		**x**		**x**
Texas	No	No. Consumers subject to surprise bills on top of cost sharing. Not held harmless from surprise bill even if mediation-eligible	No, mediation not directly between parties in dispute. Consumers must initiate mediation and participate in part of the process. Mediation not available for all surprise emergency bills	Mediation eligibility available outside of ER but limited to bills from some providers at certain facilities and over $500
Some state protections are only available for care at in-network facilities or from certain facility-based physicians				

Sources:

Jack Hoadley, Sandy Ahn, and Kevin Lucia. “Balance Billing: How Are States Protecting Consumers from Unexpected Charges?” The Center on Health Insurance Reform, June 2015, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2015/rwjf420966

Christina Cousart, "Answering the Thousand-Dollar Debt Question: An Update on State Legislative Activity to Address Surprise Balance Billing," National Academy for State Health Policy, April 2016, http://nashp.org/wp-content/uploads/2016/04/BCBS-Brief.pdf

Consumers Union, " Getting Started on Surprise Medical Bills: An Advocates Guide," November 2015, http://consumersunion.org/wp-content/uploads/2015/11/SurprisebillsAdvocatesGuide.pdf

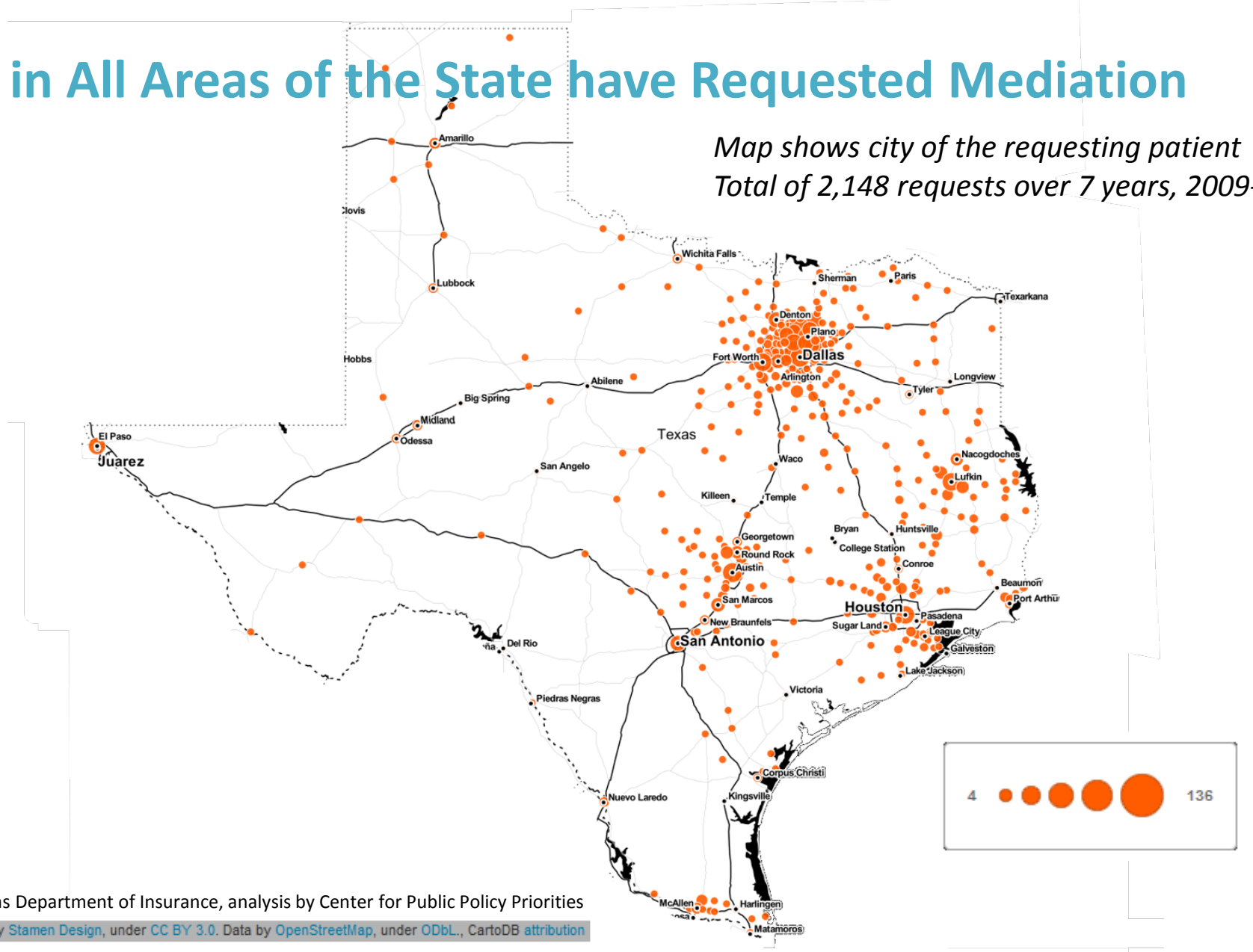
Kaiser Family Foundation, "State Restrictions Against Providers Balance Billing Managed Care Enrollees," March 2013

Consumers in All Areas of the State have Requested Mediation

Cities with most balance billing mediation requests

City	Consumers requesting mediation
AUSTIN	136
DALLAS	135
PLANO	84
HOUSTON	81
LUFKIN	77
FORT WORTH	48
FRISCO	40
MCKINNEY	33
EL PASO	32
CARROLLTON	27
ALLEN	26
IRVING	25
RICHARDSON	23
SAN ANTONIO	23
DENTON	22
ARLINGTON	21
GARLAND	20
LEWISVILLE	19
SAN MARCOS	19
NACOGDOCHES	18
THE COLONY	18

Map shows city of the requesting patient
Total of 2,148 requests over 7 years, 2009-2015



Data from Texas Department of Insurance, analysis by Center for Public Policy Priorities

Network adequacy

What is network adequacy?

- To be adequate, a health plan's network must provide consumers with the right care, at the right time, without having to travel unreasonably far
- It's also important that consumers be able to obtain care through their network in a language they can understand

Why is network adequacy important?

- In most health plans, patients who want to avoid extra fees besides the standard deductible, copayment, or coinsurance must see the providers in that plan's network. But if the network is not adequate, patients will end up either forgoing care or paying more money to see doctors outside of the network to get needed care.

Why is examining network adequacy important right now?

- Health coverage alone does not guarantee access to timely, affordable, high-quality care. The network adequacy problems that consumers have always faced (long before the passage of the Affordable Care Act) —such as finding the right health care providers in their plan's network or obtaining accurate information about which providers are in their network—remain.
- "Narrow network" plans have increased, especially in the Health Insurance Marketplace, as insurers compete on price and work to keep premiums down

Can consumers get the right care, in a timely manner, without having to travel unreasonably far?

Adapted from Families USA, Network Adequacy 101: An Explainer, http://familiesusa.org/product/network-adequacy-101-explainer

Essential elements of an adequate network

The right care

- An adequate network includes providers that can address all of patients' health care needs and deliver all of the services that the plan covers in its benefits package. It must have the right balance of primary care providers, specialists, and quality medical facilities such as hospitals, labs, and clinics. And it must have them in sufficient number relative to the number of enrollees in the plan.
- Enrollees with specific medical needs should be able to see the type of provider best-suited for their condition, whether that provider is a certain type of specialist or a non-physician provider.
- Plans should also consider information about the quality of providers and facilities when forming their networks. Composition, size, and quality matter.

Care at the right time

- To be adequate, a network must enable enrollees to receive care in a timely manner based on their medical needs. For example, patients with emergent health care needs should be able to see a provider right away, and patients who are referred to a specialist within a given timeframe should not struggle to get an appointment. Thus it's important that networks not only have the right providers, but also enough of them to meet patient needs for timely care.

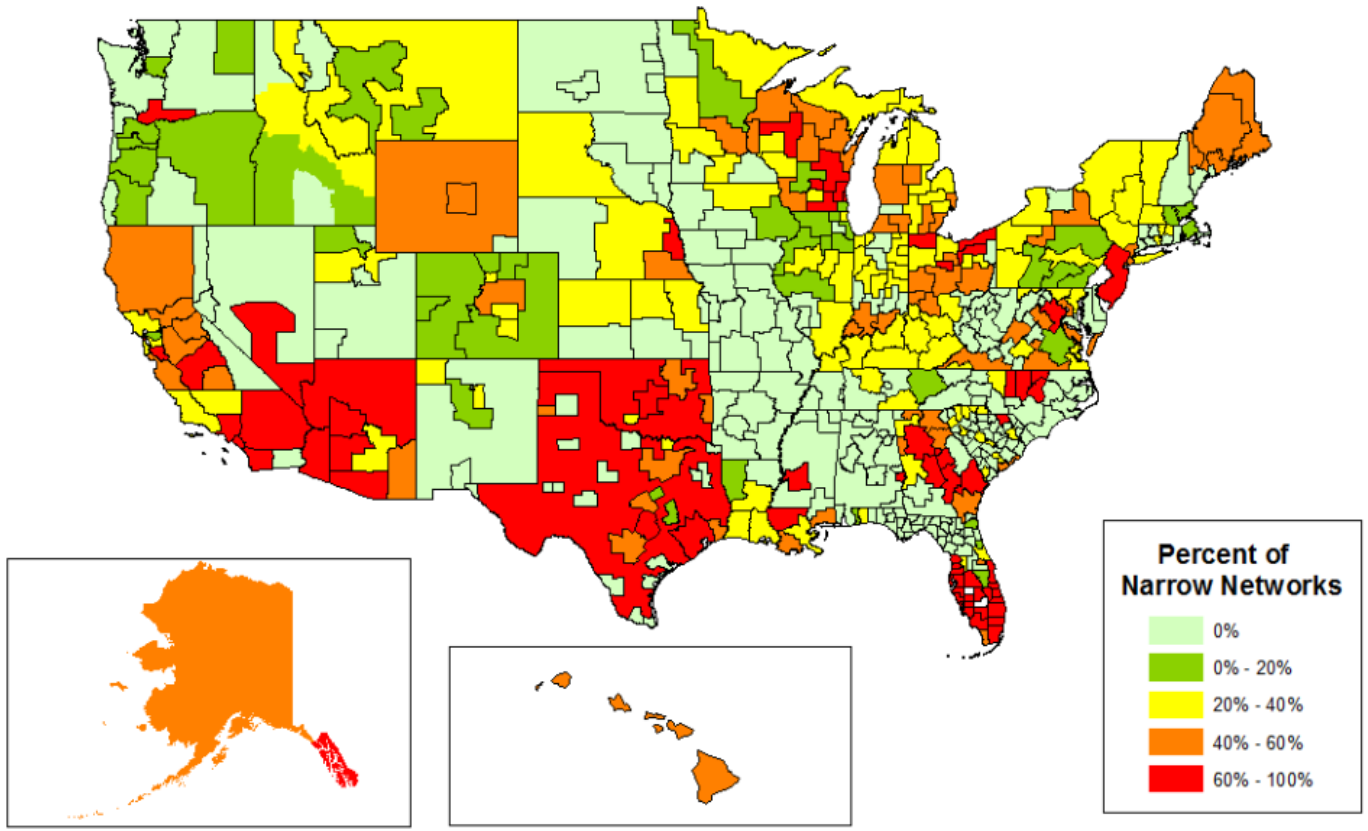
Geographic accessibility

- Health plan enrollees should be able to see providers and facilities without having to travel unreasonably far. Sufficient numbers of providers and facilities should be located in or within a reasonable distance from enrollee communities to meet needs for timely, quality care. In communities where large portions of the population rely on public transportation, many in-network providers and facilities should be accessible that way.

Adapted from Families USA, Network Adequacy 101: An Explainer, http://familiesusa.org/product/network-adequacy-101-explainer

A look at Marketplace physician networks

Percent of Narrow Physician Networks in 2014
"Silver" Level Plans by Marketplace Rating Area



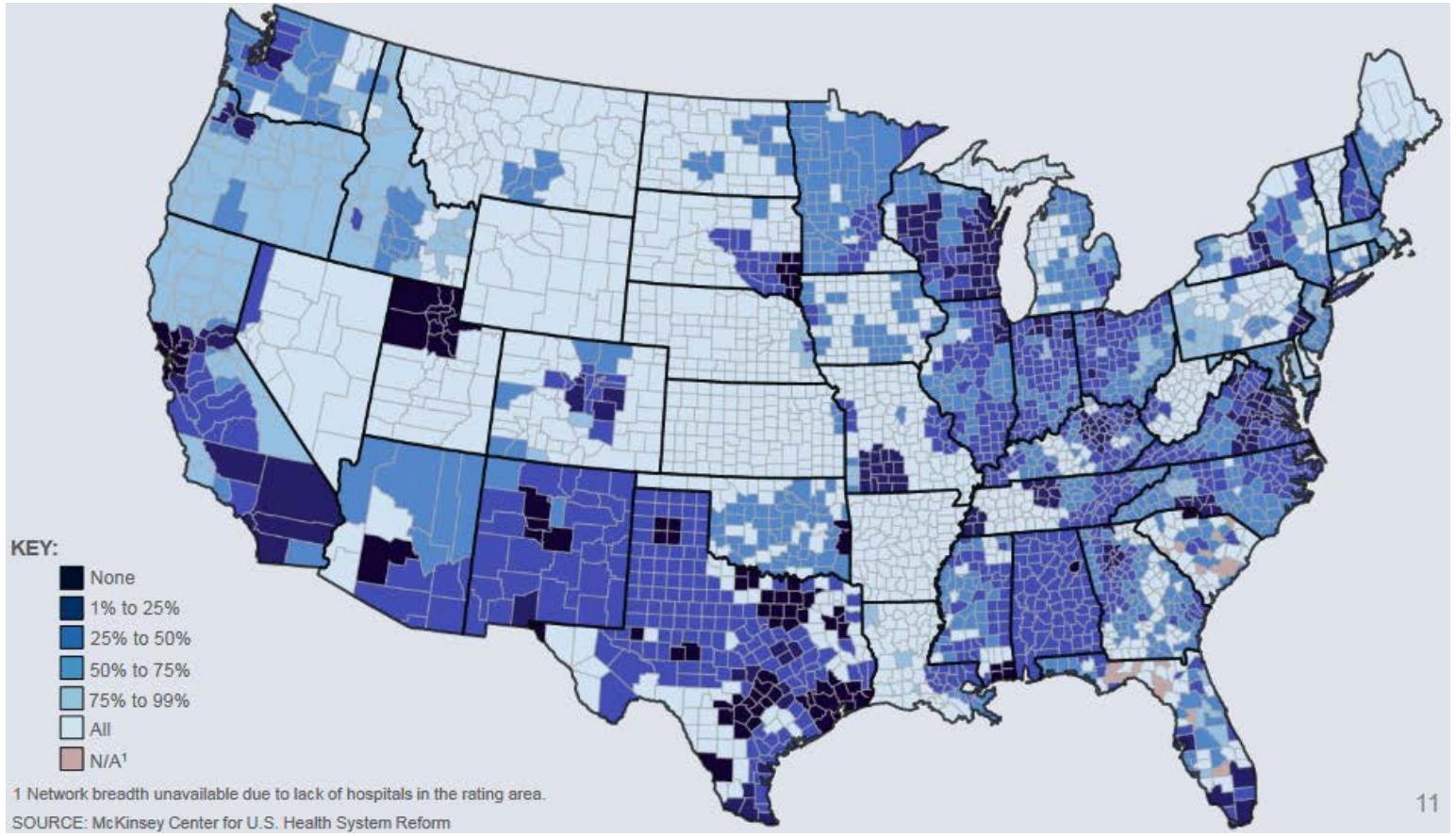
"T-shirt Size" of Networks in Texas Marketplace, 2015	
X-small	45%
Small	27%
Medium	9%
Large	0%
X-large	18%

73% of Texas Marketplace networks are narrow, compared to **41%** nationwide

State Variation in Narrow Networks on the ACA Marketplaces, Leonard Davis Institute of Health Economics and Robert Wood Johnson Foundation, August 2015, http://ldi.upenn.edu/sites/default/files/rte/state-narrow-networks.pdf. Network size based on the fraction of physicians participating in each rating area. "T-shirt size" categories are x-small (less than 10%); small (10-25%); medium (25-40%); large (40-60%); and x-large (more than 60%). "Narrow" includes both x-small and small networks, with under 25% of available providers participating.

A look at Marketplace hospital networks

Percent of Hospital Networks Classified as Broad by County, 2016



- **Texas and Utah saw the largest drop in 2016 in the proportion of broad networks**
- **Nationwide, broad network silver plans cost 22% more than narrowed network plans with same carrier and plan type**

McKinsey Center for U.S. Health System Reform, "Hospital networks: Perspective from three years of exchanges, March 2016, http://healthcare.mckinsey.com/sites/default/files/McKinsey%20Reform%20Center_2016%20Exchange%20Networks_FINAL.pdf. Broad network: more than 70% of hospitals in a rating area participate in the network

A look at Marketplace hospital networks

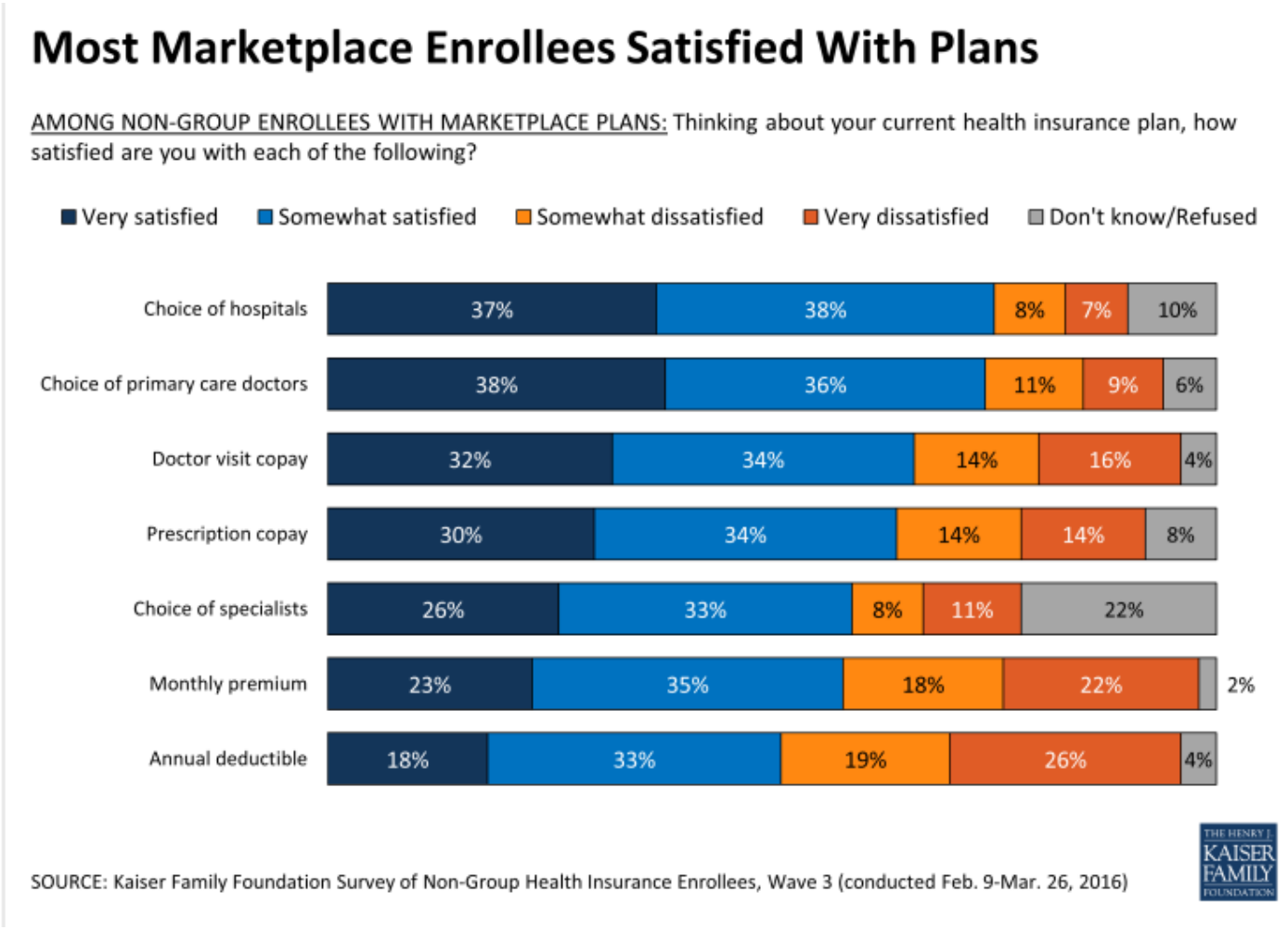
Most Regionally Ranked Hospitals Stay In-Network with Some TX Marketplace Plans in 2016, But Participation Declines

Hospitals (from list of "Best Regional Hospitals" by *U.S. News and World Report*)	**Region**	**# of Marketplace networks in which hospital participates**		**Change in # of networks**
		2015	**2016**	
Baylor University Medical Center	DFW	4	2	-2
Doctors Hospital at Renaissance	McAllen/Edinburg	6	4	-2
Edinburg Regional Medical Center	McAllen/Edinburg	2	2	Same
Houston Methodist Hospital	Houston	3	0	-3
Methodist Stone Oak Hospital	San Antonio	4	2	-2
Seton Medical Center	Austin	4	3	-1
St. David's Medical Center	Austin	5	2	-3
University Health System	San Antonio	4	1	-3
UT Southwestern University Hospital	DFW	1	0	-1
Memorial Herman	Houston	4	2	-2

- **8 of 10 regionally ranked hospitals are in-network with at least one Marketplace insurer in 2016**
- **Plan choices narrowed for consumers loyal to a specific hospital**
- **Number of TX Marketplace networks cut in half, from 37 in 2015 to 18 in 2016**

Robert Wood Johnson Foundation, "Most Regionally Ranked Hospitals Stay In-Network with Marketplace Plans, But Participation Declines," February 2016, http://www.rwjf.org/content/dam/farm/reports/issue_briefs/2016/rwjf426368

Marketplace consumers generally satisfied with networks



Nationally, Marketplace most enrollees report satisfaction with their plan's network:

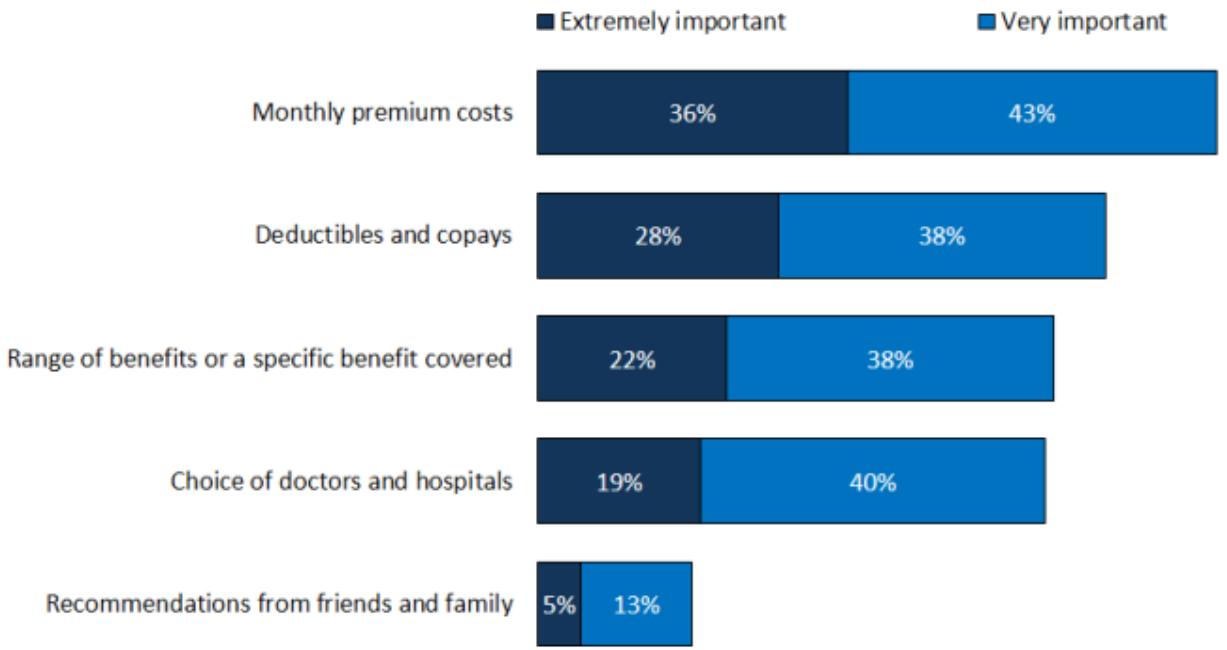
- **75% satisfied with choice of hospitals**
- **74% satisfied with choice of primary care doctors**
- **59% satisfied with choice of specialists**

Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, Wave 3*, May 2016, http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

Individual market consumers more focused on costs than networks

Costs More Important Than Other Factors In Plan Choice

AMONG NON-GROUP ENROLLEES WITH ACA-COMPLIANT PLANS: Percent who say each was an "extremely" or "very" important factor in choosing their current health plan:

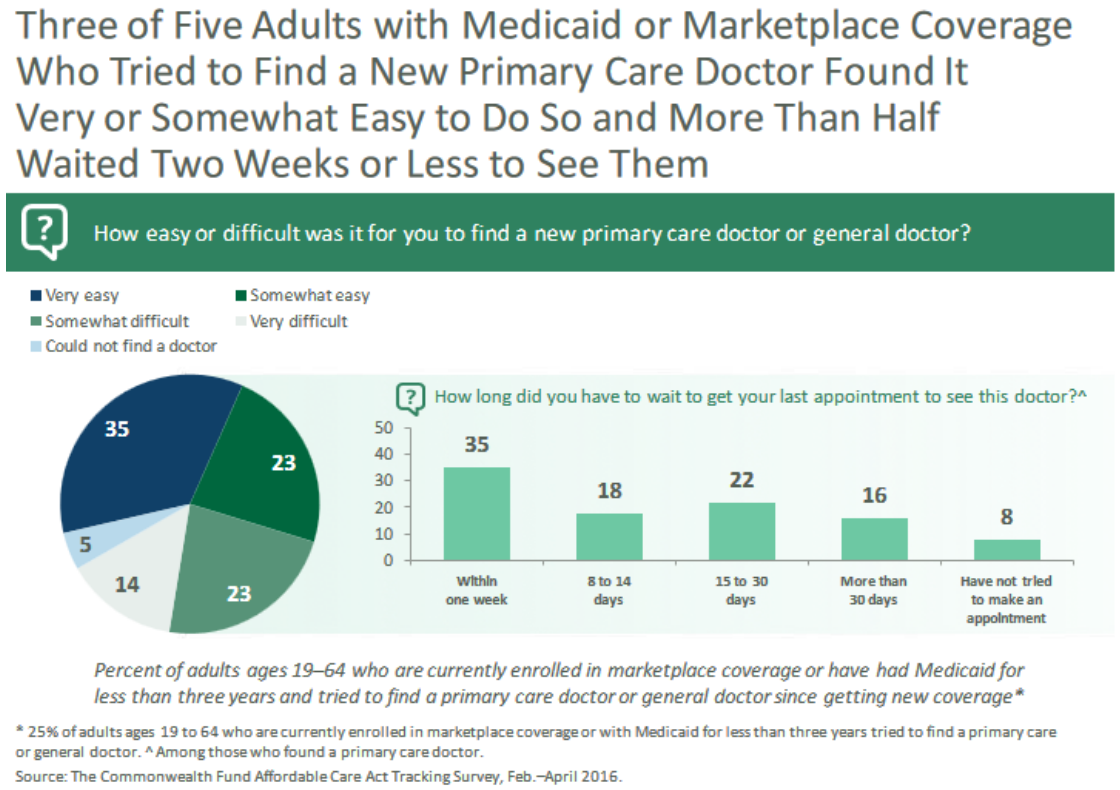


SOURCE: Kaiser Family Foundation Survey of Non-Group Health Insurance Enrollees, Wave 3 (conducted Feb. 9-Mar. 26, 2016)

- **Nationally, 79% of consumers say premium costs are very important**
- **Nationally, 59% of consumers say networks are very important**

Kaiser Family Foundation, *Survey of Non-Group Health Insurance Enrollees, Wave 3*, May 2016, http://kff.org/health-reform/poll-finding/survey-of-non-group-health-insurance-enrollees-wave-3/

Americans newly insured through the Marketplace or Medicaid report access similar to all insured



Access to primary care doctors nationally is similar is to that for all insured adults:

- **58% of Marketplace or new Medicaid adult enrollees say finding a PCP was very or somewhat easy**
- **57% of insured adults overall say finding a PCP was very or somewhat easy**

Wait times for specialist appointments is similar is to that for all insured adults:

- **38% of Marketplace or new Medicaid adult enrollees got an appointment within 1 week**
- **42% of insured adults overall got an appointment within 1 week**

The Commonwealth Fund, *American's Experience with ACA Marketplace and Medicaid Coverage: Access to Care and Satisfaction,* May 2016, http://www.commonwealthfund.org/~/media/files/publications/issue-brief/2016/may/1879_collins_americans_experience_aca_marketplace_feb_april_2016_tb.pdf

We believe in a Texas

that offers everyone the chance
to compete and succeed in life.

We envision a Texas

where everyone is healthy, well-educated,
and financially secure.

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