Policy Corner

By Paul J. Giancola

BALANCE BILLING CURTAILED BY NEW AZ LAW

Over the last few years, a chorus of news reports has brought to the attention of state legislatures what is now widely recognized as the "problem" of "surprise medical out-of-network bills." This is a term commonly used to describe charges arising when an enrollee of a health plan receives care and a medical bill, from a health care provider who does not belong to their health insurer's provider network. These bills are typically for medical services that are rendered at an in-network health care facility or at the request of an in-network physician. The enrollee is then billed by the out-of-network provider for the full amount of the charge that is in excess (the balance) of the reimbursable amount under the enrollee's health plan. In contrast, in-network providers are generally prohibited from balance billing a patient under their contracts with the plan.

This "problem" usually arises when the patient's in-network provider obtains out-of-network providers to participate in the patient's care. The most common out-of-network providers are anesthesiologists, radiologists, pathologists, surgical assistants, and emergency department on-call specialists. The issue has grabbed the attention of state legislators because in addition to news reports, many legislators have had constituent complaints and personal experiences with a surprise bill.

The prevalence of a surprise bill is being studied. A 2011 New York Department of Financial Services study of 2000 complaints found the average out-of-network emergency bill was $7,000, of which insurers paid 46% with the enrollee responsible for the remaining amount. Similarly, for non-emergency in-hospital care, the New York study found that on average out-of-network assistant surgeons billed $14,000, while insurers paid on average only 13% of the bill. The study found that on average radiologists billed $5,400, while insurers paid on average 46% of the bill. A 2013 Texas study found that between 41% and 68% of the billed charges for emergency related physician services at in-network hospitals were submitted by out-of-network physicians. *The New England Journal of Medicine* reported in November 2016 that 22% of patients who visited an emergency department received a surprise bill from an out-of-network provider.

A number of states, including California, Colorado, Connecticut, Florida, New York, Illinois, Indiana and Texas, have responded by enacting laws specifically limiting balance billing by out-of-network providers under certain circumstances. New York has the most comprehensive state law protection against surprise bills.

Components of a "surprise bill"

The surprise bill usually involves two components. The first component is the difference in patient cost-sharing between in-network and out-of-network providers. For example, in a plan that provides coverage for in-network and out-of-network providers, an enrollee might owe 20% of "allowed charges" (the reimbursement allowed by the insurer regardless of the amount of the billed charge) for in-network services and 40% of allowed charges for out-of-network services. An enrollee may also have a plan deductible that will impact the amount of enrollee cost sharing on a bill. The second component of a surprise bill is the "balance bill." Network contracts typically prohibit providers from billing enrollees for the difference between the allowed charge and the billed charge. Because out-of-network providers have no such contractual obligation, enrollees can be liable for the balance bill in addition to any cost-sharing, including deductibles that might otherwise apply.

Senate Bill 1441

The Arizona legislature responded to surprise bills when it passed and Governor Ducey signed, on April 24, 2017, S.B. 1441. The bill amends Title 20 of the Insurance Law, Section 20-3102 by adding Article 2 "out-of-network claim dispute resolution."

S.B. 1441, introduced by Sen. Debbie Lesko, defines a "surprise out- of- network bill" as a bill for a health care service, laboratory service or durable medical equipment (collectively "services") provided in a network facility by a provider that is not contracted. The enrollee may dispute the amount of the bill by a dispute resolution process the starts

with a teleconference followed by final binding arbitration, if requested and certain criteria are met. The highlights of the new law include:

Disclosure notice of right to dispute resolution ("notice")

- The Arizona Department of Insurance ("DOI") in conjunction with health care licensing boards, will develop a notice that outlines an enrollee's right to dispute a bill.
- Insurers must include the notice in each explanation of benefits to enrollees that involves covered services rendered by an out-of-network provider.
- A provider, on request, must provide the notice to the enrollee.
- The DOI will post information on its website for consumers regarding:
  - what constitutes a surprise bill;
  - how to try to avoid a surprise bill; and
  - how the dispute resolution process may be used to resolve a surprise bill.
- The Notice must inform an enrollee that:
  - the provider is not an in-network contracted provider;
  - the estimated total cost to be billed;
  - that if the enrollee or their authorized representative signs the disclosure, the enrollee may have waived any rights to dispute resolution.

Criteria to qualify as a surprise bill

- The services were provided for an emergency condition at a network facility; or
- The services were not provided due to an emergency condition; however, the provider either did not disclose the notice or did not provide it within a reasonable amount of time before the services were provided; or
- The services were not provided due to an emergency condition and the enrollee or the enrollee's representative chose not to sign the notice.

Criteria to initiate a dispute of a surprise bill

- The surprise bill must meet one of these requirements to qualify for dispute:
  - the enrollee has resolved any health care appeal against the insurer following the insurer's initial adjudication of the claim;
  - the amount of the bill for which the enrollee is responsible after deduction of the enrollee's cost sharing requirements and the insurer's allowable reimbursement is at least $1,000.
- The enrollee may request dispute resolution of a bill by submitting a request on a DOI prescribed form.
- The DOI, on receipt of the request, will notify the insurer and provider.

Teleconference

- The DOI, in an effort to settle the bill before arbitration, will arrange an informal settlement teleconference within 30 days after receipt of the request.
- The insurer, as part of the teleconference, will provide the amount of the enrollee's cost sharing requirements under the enrollee's health plan based on the adjudicated claim.
- The enrollee must participate in the teleconference; the enrollee has the option of participating in the arbitration.
- The insurer and provider must participate in both the teleconference and the arbitration.
- If either the insurer or the provider fails to participate in the teleconference, the nonparticipating party will be required to pay the total cost of the arbitration.
- If the dispute has not been settled or a party has failed to participate in the teleconference, the DOI will initiate the process to appoint an arbitrator.

Criteria to initiate arbitration of a surprise bill

- The enrollee must pay or make arrangements in writing to pay to the provider the total amount of the enrollee's cost sharing due for the services contained in the bill;
- The enrollee must pay to the provider any amount received from the enrollee's insurer as payment for the out-of-network services; and
- The insurer, if applicable, must pay its out-of-network services allowable amount due to the provider.

Arbitration

- The arbitration will be held within 120 days of the request for dispute resolution in the county in which the services were provided, and it may by agreement be conducted over the telephone.

- The arbitrator determines the final amount the provider is entitled to receive as payment.
- The arbitrator may consider various factors submitted by the parties in evaluating the amount of the bill, including the following:
  - the average contracted amount that the insurer pays for the health care services in the county where the services were performed;
  - the average amount that the provider has contracted to accept for the services in the county where the services were performed;
  - the amount that Medicare and Medicaid pay for the same services;
  - the provider's direct pay rate, if any;
  - other information in determining whether a fee is reasonable and not excessive, including the usual and customary charges for services that were performed by a provider in the same or similar specialty, and provided in the same geographical area; and
  - any other reliable databases or sources of information on the amount paid for the services in the county where the services were performed.
- All pricing information confidential.
- The insurer and provider share the costs of the arbitration equally; the enrollee is not responsible for any portion of the cost of the arbitration.
- The insurer must pay its portion of the payment resulting from the teleconference or the amount awarded by the arbitrator within 30 days of resolution of the claim.

Balance billing prohibited

- The enrollee is responsible for only the amount of the enrollee's cost sharing requirements (defined as coinsurance, copay and deductible requirements) and any amount received by the enrollee from the enrollee's insurer as payment for out-of-network services.
- A provider is prohibited from issuing any additional balance bill to the enrollee for the service.

Miscellaneous

- The bill does not apply to the following:
  - health care services that are not covered by the enrollee's plan;
  - limited benefit coverage as defined in statute;
  - charges for services subject to a direct payment agreement;
  - plans that do not include coverage for out-of-network services, unless otherwise required by law;
  - state health and accident coverage for full-time officers and employees of the State of Arizona and their dependents.
- Each year DOI is to provide a detailed report to the Governor and the Legislature on the resolution of surprise bills, including the frequency of requests, results, requests by specialty, insurer, geographic area, and average percentage by which surprise bills were reduced.
- The law becomes effective on January 1, 2019.

Comments

S.B. 1441 was originally modeled after Texas' law – the major components of which are an informal teleconference between the patient, the provider, and the health plan. In Texas, teleconference resolves 94% of qualifying surprise bills. For the small number of remaining bills, Texas provides an escalating sequence of dispute resolution with mediation followed by arbitration.

Throughout the 2017 Legislative Session, the Arizona Medical Association (ArMA) led the effort by organized medicine and worked closely with specialty societies to educate lawmakers, and to prevent negative unintended consequences and burden on physicians and patients.

S.B. 1441 reflects an uneasy and technically complex compromise between insurers and providers. The benefit for providers is that it provides a mechanism to quickly resolve and obtain reasonable compensation for services soon after the services have been billed, rather than having to pursue the patient and the insurer for payment. The highlight for providers is that for those enrollees who pursue arbitration, the price of admission is to first resolve the patient's cost sharing (either paid or to be paid under a fee agreement) and the insurer's out-of-network allowable. Many providers have been frustrated by insurers who pay the patient their out-of-network allowable, but the patient does not pay it to the provider. When accessed by the enrollee, S.B. 1441 prevents this from happening. In addition, it requires the insurer pay the provider the applicable out-of-network payment. Anecdotal evidence suggests that many providers consider payment of such amounts by the patient and the insurer to be a "win." Moreover, insurers indicated during negotiations on the bill that avoiding a costly arbitration and resolving claims typically results in a willingness to offer the provider at the teleconference an amount that while less than the billed charge is more than the in-network contracted rate.

If the bill is successful, it is because all parties have the incentive to resolve surprise bills without incurring the time and expense of arbitration. There may, however, be unanticipated consequences. For example, will the bill impair the free market and force physicians to contract with insurers and accept insurance rates? Or will some physicians decide to stop providing services at in-network facilities such as hospitals because they cannot obtain adequate and timely payment? Lastly, the bill as written is merely a framework. The DOI must still formulate regulations to implement the bill. The implementation of the bill is delayed until January 1, 2018, allowing for legislative changes if deemed necessary. ArMA will be engaged in the rule-making process and representing physician concerns prior to final implementation.

Stay tuned; time and experience will ultimately tell the story of the benefits and unintended consequences of the bill.

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