Insurance Network Adequacy and Transparency

(Policy Number 17-01)

Policy Statement: The American Society for Clinical Pathology (ASCP) supports increased health insurance network adequacy and transparency to minimize the incidence of out-of-network billing.

I. Background and Rationale

According to a 2015 Consumer Reports National Research Center survey, 30 percent of privately insured Americans in the previous two years had received a so-called surprise bill when their insurance company paid less than expected. Additionally, among those who received a surprise bill, nearly one in four received it from a provider for whom they were not expecting a bill.[1] Instances of surprise billing – wherein a patient (consumer) may receive a bill for an episode of care or service they believed to be in-network and therefore covered by their insurance, but was in fact out-of-network – are increasing.

Conversely, the process of balance billing occurs when a provider seeks compensation for an outstanding balance after the insurance company remits its payment on the bill. Out-of-network providers can bill patients for the remaining balance. Therefore, patients are increasingly being held accountable for unexpected, unaffordable medical bills. Furthermore, these bills are contributing to medical debt. According to a Kaiser Family Foundation/New York Times survey, "among non-elderly insured adults who were experiencing difficulty paying their medical bills, charges from out-of-network providers were a contributing factor about one third of the time.[2]

Surprise billing occurs most often in emergency situations, but specialties like pathology, radiology, and anesthesiology are affected as well.

II. Policy Backdrop

In this document, ASCP outlines its view that policies should be adopted *that promote insurance network adequacy and transparency, while ensuring sufficient compensation for providers, thereby reducing the incidence of surprise billing*. Insurers must be required to provide adequate networks wherein reasonable access to a sufficient number of services and in-network providers, including specialty physicians such as pathologists, is included. Further, patients should be given accurate provider directories and information on an insurance plan's network composition, to increase transparency.

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[1] Consumer Reports National Research Center. Surprise Medical Bills Survey: 2015 Nationally-Representative Online Survey. May 5, 2015. http://consumersunion.org/wp-content/uploads/2015/05/CY-2015-SURPRISE-MEDICAL-BILLS-SURVEY-REPORT-PUBLIC.pdf

[2] Hamel, L., et al. The Burden of Medical Debt: Results from the Kaiser Family Foundation/New York Times Medical Bills Survey. Jan. 5, 2016.

The Affordable Care Act (ACA) included many reforms intended to provide more access to affordable, high quality health care, including a provision for Qualified Health Plans to include adequate networks. However, the legislation has had the unintended consequence of allowing narrowed insurance networks to proliferate in the new marketplaces. Consumers increasingly have the option to choose plans that have lower premiums but limit choice of provider because insurers are narrowing their networks in an effort to control or reduce costs. As insurers narrow their networks, providers are left with the difficult choice of accepting reimbursement that is inadequate, billing patients for the difference, or going unpaid for their services. Many doctors would like to be "in-network," but some insurance companies are failing to negotiate rates that providers can afford. ASCP advocates for adoption of policies to evaluate hospital-based physicians as part of network adequacy, and opposes policies that limit balance billing, which could in turn limit patient access to in-network hospital-based physicians.

Several states (e.g., NY, CT, CO, FL, TX) have adopted legislative approaches to address the issue that generally fall into four categories:[3]

a. *Disclosure and transparency*

Disclosure and transparency provisions make consumers aware that they may face balance billing in situations where they are unable to use network providers, such as in emergency situations, or if patients encounter out-of-network providers as part of a care team. It is standard in many states to require insurers to include language in notices to consumers and plan summaries about the consequences of purposefully going out of network. Some states have gone further to require notices at the point of service alerting consumers that they may experience balance billing. In addition, some state provisions have focused more broadly on network transparency through up-to-date provider directories. It remains to be seen, however, how valuable these protections are to consumers as the disclosure may simply be considered another piece of paper added to the many they receive during a typical health encounter.

b. *Hold harmless provisions*

Hold harmless provisions require insurers to hold plan members harmless by paying providers their billed charges (or some lower amount that is acceptable to the provider – in some states this is the Medicare rate plus a certain percentage). These provisions are generally used in emergency care situations, but should be employed with caution as costs incurred by insurers may eventually be passed on to consumers through higher premiums. Additionally, hold harmless provisions may require the patient to be aware that they are able to pass their bill to the insurer rather than pay the billed amount.

c. *Adequate payment*

Some states have specific provisions requiring insurers to pay non-network providers at the usual and customary rate they pay to in-network providers. Other states refer providers and

[3] Hoadley, J., Ahn, S., Lucia, K. Balance Billing: How Are States Protecting Consumers from Unexpected Charges?. The Center on Health Insurance Reforms: Georgetown University Health Policy Institute. June 2015.

insurers to an independent mediation or dispute resolution process to settle on a fair rate of payment. Connecticut has provisions in place for emergency situations that allow providers to bill the greatest of the following three amounts: (a) in-network rates; (b) usual, customary, and reasonable rates; or (c) Medicare rates. In this case, "usual, customary, and reasonable rates" means the eightieth percentile of all charges for a particular service, performed by the same or similar provider, in the same geographical area. The usual and customary rate information is reported and maintained by a non-profit, third party organization and cannot be affiliated with any health insurance carrier.[4] By utilizing a neutral third party to set the usual and customary rates, Connecticut legislation removes concerns over either providers or insurers setting rates that each party may consider unreasonable.

New York in particular has had success with their consumer protection legislation. Policymakers have combined several approaches including disclosure, transparency, and a process to resolve payment disputes between providers and health plans. New York law bans balance billing in emergency situations and in situations wherein a consumer assigns the provider's claim to their insurer.[3] Further, New York's dispute resolution process utilizes physicians in active practice that choose either the provider's original billed amount or the plan's amount – not any amount in the middle. The independent dispute resolution physicians must consider the patient's characteristics, the provider's training and experience, and the usual and customary rates.[3] This process is designed to make it more attractive for providers and health insurance plans to set reasonable rate levels.

d. *Balance billing prohibitions*

Several states prohibit balance billing from out-of-network providers beyond any cost sharing. In some states, the ban applies only if the out-of-network provider accepts payment for the claim directly from the insurer, even though a network relationship does not exist.[3] Providers must agree to accept the insurance plan's payment as payment in full and the consumer is only held liable for cost sharing. Balance billing prohibitions place the provider at risk for accepting a rate amount less than the one billed – or even an amount the provider considers reasonable. Therefore, a compromise must be struck between placing insurers and/or providers at risk for all or most of the financial burden.

e. NAIC Model Act

In addition to state efforts to curb surprise billing practices, the National Association of Insurance Commissioners (NAIC) has adopted a model act for health plan network adequacy that includes some patient protections. While NAIC model acts do not have the force of law, they often encourage state legislative action. For example, 20 states had adopted the previous NAIC model act on network adequacy.[5] In addition, some federal health insurance regulations cite NAIC model act standards. The revised (as of Nov. 2015) model act would apply new standards for in-network facilities that contract with non-network

[4] State of Connecticut Senate Bill No. 811. Public Act No. 15-146. An Act Concerning Hospitals, Insurers, and Health Care Consumers. Effective Oct. 1, 2015.
[5] Pollitz, K. Surprise Medical Bills. Kaiser Family Foundation Issue Brief. Mar. 17, 2016.

facility-based providers. For balance billing amounts, non-network providers would be required to offer patients three choices: (1) pay the balance bill; (2) submit the claim to a mediation process for amounts greater than $500; or (3) rely on any other rights or remedies that exist in a particular state.

III. Recommendations

Although passing meaningful legislation can be challenging because of the at-times conflicting views of the stakeholders involved (insurers, patients, and providers), most agree that patients should not be caught in the middle of payment disputes. In order to create policies with robust patient protections, the following components could be included:

a. Adequate insurance networks that are inclusive of hospital-based providers to minimize the need for balance billing;

b. Insurance rates that are established based on usual, customary, and reasonable rates and maintained in an independent third-party database;

c. Hold harmless provisions that require insurers to hold plan members harmless by paying providers their billed charges (or some other agreed-upon amount);

d. A mediation or dispute resolution process wherein consumers are not required to initiate proceedings;

e. Disclosure rules beyond standard notices that require insurers to warn patients if their network does not include hospital-based physicians at an in-network hospital.

IV. Conclusion

In conclusion, ASCP supports policies that fully inform patients of the possibility that they will be billed by an out-of-network provider; ensure insurance network adequacy by including hospital-based clinicians; create price and insurance coverage transparency; sufficiently reimburse health care providers such as pathologists; and remove patients from payment disputes.