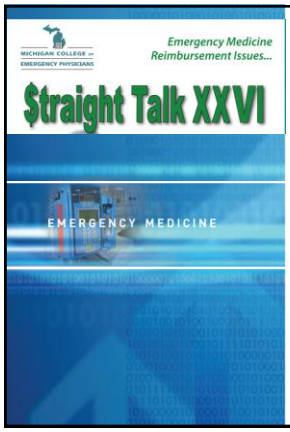

Out of network & balance billing restrictions: coming to a state near you (it's a question of when not whether)

Ed Gaines, JD, CCP
Chief Compliance Officer
Emergency Medicine Division
Zotec Partners, LLC
egaines@zotecpartners.com
Greensboro, NC
877-271-2506

Objectives and Outline for discussions:

- Review of basic concepts
- Current challenges & opportunities
- Solutions & approaches: gov't relations (GR) and public relations (PR) & state case studies.
- Review work product of stakeholders carrying the flag for EM & the "House of Medicine":
  - ACEP/EDPMA Joint Task Force (JTF)
  - AMA and multi-specialty coalition
  - Physicians for Fair Coverage (PFC)
  - State ACEP chapters & medical societies

Are we here or there?

What's at stake here?

- *"Balance Billing: The Lose-Lose—Ban it? Doctors lose dollars. Support it? Doctors Anger Patients."*
- Article in *ACEP Now* by Dr. Liam Yore, FACEP (Nov. 2015)
- *"When CA issued a blanket ban on balance billing, payments to physicians by carriers dropped drastically, by 20% overall and up to 33% by some payers."*
  - *Citing Pao B, Riner M & Chan TC, West J Emerg Med 2014; 15(4): 518-522.*

The alphabet soup of advocacy organizations & stakeholders:

- ACEP and its state chapters
  - Reimbursement and State Leg. Committees.
- EDPMA: ED groups + ED RCMs
  - The ACEP/EDPMA Joint Task Force (JTF): Year 4
- Physicians for Fair Coverage, Ltd. (PFC): multi-specialty focused
- AMA and state medical societies: June 2017 Resolution.
- ASA
- ACR

Challenges & Opportunities

Bad data, Bad Press, Bad Payor Practices and the threat of pegging

out of network (OON) reimbursements to Medicare.

How many OON bills have been submitted this yr. to state legislatures?

Answer: 127 OON bills introduced in 33 states

The Seattle Times

Insurance commissioner targets ER's 'surprise' medical bills

Originally published January 19, 2016 at 6:18 pm | *Updated January 19, 2016 at 8:33 pm*

Health Affairs Blog

Stopping Surprise Medical Bills: Federal Action Is Needed

Loren Adler, Mark Hall, Caitlin Brandt, Paul B. Ginsburg, and Steven Lieberman

February 1, 2017

WFAA abc WFAA.com A TEGNA Company

Surprise medical bills hit huge numbers of Texans, study finds

7

Bad research: NEJM Nov. 2016:

Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise

Zack Cooper, Ph.D., and Fiona Scott Morton, Ph.D.

Although the Affordable Care Act has increased the number of Americans with health insurance, a 2014 survey found that 39% of insured people still have trouble paying medical bills.[1] A major source of financial hardship for patients comes from surprise bills from physicians who are not in their insurance network. Recent media reports have described large and troubling surprise bills from anesthesiologists, radiologists, and surgeons who assisted during routine procedures.[2] Surprise bills from emergency physicians have also been a source of concern and are representative of the wider problem. U.S. hospitals generally contract with physician groups to

N ENGL J MED 375;20 NEJM.ORG NOVEMBER 17, 2016 1915

- Claims data from "a large commercial insurer"—fact: health plan has <2% of US ED visits
- Ave. in network ED physician was reimbursed 297% of MCA vs. 159% for IM office visits.
- OON average ED physician U & C charges at 798% of MCA.
- Ave. OON ED Pt balance was $623.
- "The Whopper": maximum ED U & C was $19,603.
- ACEP and EDPMA both issued press releases and requested meeting with editorial board.
- Article in the January 2017 edition of *ACEPNow* by Drs. Parker and Stanton highlighting NEJM bias:
  - http://www.acepnow.com/article/acep-outlines-flaws-biases-new-england-journal-medicine-story-balance-billing/

8

Bad Government Data

- According to Dr. Nathan Schlicher, Pres. WA-ACEP:
  - For over a year WA-ACEP asked Office of the Insurance Commissioner (OIC) for data
  - No answer
- In live testimony, OIC claimed 17.2% (294K) of all WA claims analyzed were BB
- Month later (after the news coverage), the data was released: 1.6%

Washington State Emergency Department Out of Network Billing Survey as of Nov. 2, 2015

Question	Total
How many total ED visits billed in WA state during 2014?	752,355
Total Out of Network Visits?	29,812
Average percent of OON Visits?	3.96%
Average collection amounts?	$428.75
Average patient responsibility on claim?	$127.52
Total volume of Patient Responsibility > $250?	2247
Average percent of Patient Responsibility > $250?	0.30%

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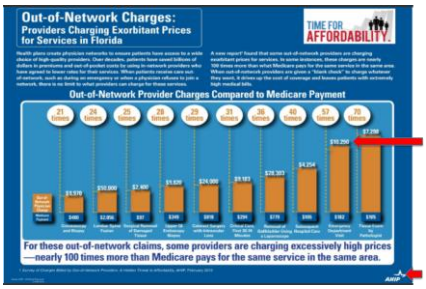
Case study--FL: How many pro fees ever are even 1/3 of this cost?



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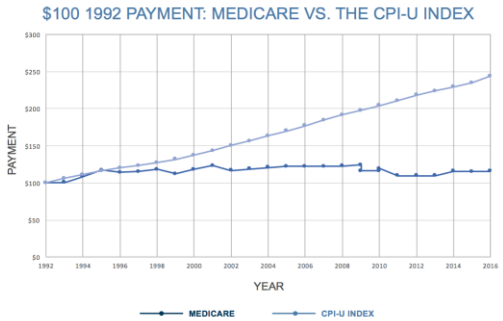
Medicare Benchmarking



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American College of Emergency Physicians
ADVANCING EMERGENCY CARE

Fact Sheet: Medicare Inflation Adjustment

Utilizing Medicare rates as a standard for determining fair payment for out of network providers is a fundamentally flawed approach because Medicare rates were never designed to represent the fair market value of healthcare services or to even cover provider costs. Additionally, Medicare rates fluctuate based on variables unrelated to the services provided, such as the federal budget.

A Medicare-based reimbursement scheme would destabilize the ED safety net and financially burden our most vulnerable hospitals, including our community and rural hospitals. Excellent emergency department care should be available in all communities, and many hospitals cannot afford to subsidize their emergency departments any further. Imposing Medicare rates as would cause many hospital emergency departments to close, or cut back on the quality of care they can offer their communities. Those most vulnerable are those serving the communities with the greatest need. There is potential that patients will find themselves hours from the nearest hospital or emergency department.

A non-profit 2016 Rand study concluded that many New Jersey hospitals would be at serious financial risk if reimbursement rates were set at 250% of Medicare, and that fully a third would be pushed into operating losses if rates were set at 90% of Medicare.

Highlighting the fundamental flaw of using Medicare as a standard, standard rates have not even kept pace with general inflation costs (see below table). Comparing Medicare payments to inflation (CPI-U), between the start of the RBRVS system in 1992 and 2016 Medicare payments have decreased by 53%. Had Medicare been used as an index for private payers in 1992 the healthcare system would have broken long ago.

KEY FACTS

53%↓

Comparing Medicare payments to inflation, between the start of the RBRVS system in 1992 and 2016, Medicare payments have decreased by 53%.

1/3

1/3 of New Jersey hospitals would have been pushed into operating losses if rates were set at 90% of Medicare.

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Why pegging OON reimbursement to Medicare is the "game over" solution for EM:

https://www.acep.org/Advocacy/Chapter-Toolkit-on-Out-of-Network-Payment-Legislation/

What is Fair Health?

- Nationwide, independent, not-for-profit
- Directory of provider charges by geozip
- Percentile (80th) can be used to set Minimum Benefit Standard
- Transparent to providers & patients

FAIR Health
Know Your Source

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Ingenix Inc., FAIR HEALTH, Inc. AND HEALTH CARE COST INSTITUTE (HCCI)

Comparison/Contrast

Organizations and Data

	Optum360, f/k/a Optuminsight Inc. and f/k/a Ingenix Inc.	FAIR Health, Inc.	HCCI
Organization	Optum360 Optum360 was formed in Oct 2013 by the merger of Dignity Health and OptumInsight. Optum is the Health Services platform of United Health Group UnitedHealth Group also owns UnitedHealthcare – started myHealthcare Cost Estimator UnitedHealth Group trades on NYSE under UNH. In 2010, the AMA v. United Healthcare lawsuit settlement of $350 million was approved by a NY federal judge regarding the Ingenix Inc. database. The AMA with several prominent state medical societies alleged that UNH's subsidiary Ingenix had engaged in RICO conspiracies and Unfair and Deceptive Trade Practices to undervalue the "usual and customary"	FAIR Health, Inc. NY 2009. Unaffiliated with any insurer or other stakeholder Conflict-free, uncompensated board of directors. Fair Health Inc. was created in 2009 after the NY Attorney General's settlement with United Healthcare over the Ingenix Inc. database (see previous notes under Optum360) Independent Not-for-Profit, tax-exempt under § 501(c)(3) created as part of legal settlement to establish transparent and accurate source of healthcare cost information for consumers, researchers, policymakers and healthcare industry.	Health Care Cost Institute, Inc., DC 2011. Tax-exempt nonprofit research corporation formed initially by four insurance companies, (three continue to participate, to provide virtual data access to researchers for selected projects.) IRS Form 990 from 2014 shows the following: Schedule B, Schedule of Contributors to HCCI: 1. UnitedHealth Group: $3.59 Million 2. Aetna Inc.: $2.72 Million; 3. Humana Inc.: $1.65 Million; 4. Kaiser Permanente: $350,000 Schedule O: Compensation to the Five Highest Paid Contractors: 1. Optum Global Solutions: $1.050 Million, consulting

- Developed by FCEP and the ACEP Reimbursement Committee.
- Why FH is the charge based std?
  - University of Chicago "NORC" report June 2014
  - Physicians for Fair Coverage (PFC) commissioned NORC report April 2017.

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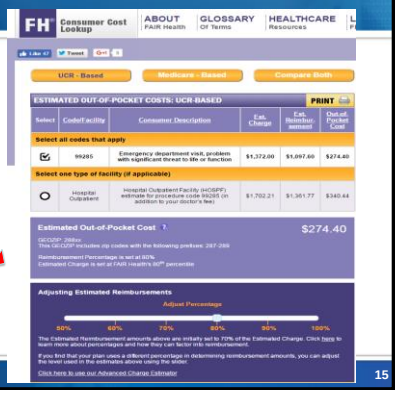
Level V (CPT 99285) OON reimbursement with Fair Health standards.

- Est. charge for 99285 geo-zip 28801: $1372
- 80th percentile reimbursement at $1098.
- 6.23 X of Medicare reimbursement for 99285 (2017=$176).
- 80th percentile standard would raise K rates also.

http://fairhealthconsumer.org/medicalcostlookup.php



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Why is it so darn hard w/ (certain) health plans to accept Fair Health? From UHC—but perhaps their history informs their policies

How Does This Affect Members?

If a health care benefit plan requires payment using the term "reasonable and customary" or similar language mentioned above with respect to medical and surgical procedures performed and billed by health care professionals or health care professional group practices, then the affiliates of UnitedHealth Group most commonly refer to a schedule of charges created by FAIR Health, Inc. ("FAIR Health") to determine the amount of the payment.

Affiliates of UnitedHealth Group frequently use the 80th percentile of the FAIR Health Benchmark Databases to calculate how much to pay for out-of-network services of health care professionals, but plan designers and administrators of particular health care benefit plans may choose different percentiles for use with applicable health care benefit plans. Members may contact the customer service line of the applicable UnitedHealth Group affiliate shown on the back of the member's health identification card to learn of the percentile applicable to the member's health plan.

https://www.uhc.com/legal/information-on-payment-of-out-of-network-benefits

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NORC Report to CCIO

CCIIO — The Center for Consumer Information & Insurance Oversight

- Paucity of sources for validated, transparent charge & reimbursement data
- The organization that best satisfies the evaluation criteria… owns the most current, comprehensive and transparent database – FAIR Health June, 2014
- PFC commissioned a follow up study for 2017: FH is the recommended standard for the OON issues (see appendix).

NORC at the UNIVERSITY of CHICAGO

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Case Study: The Peach State Experience.

- The GA OON coalition:
  1. Medical Association of GA (MAG)
  2. GA College of Emergency Physicians (GCEP)
  3. GA Society of Dermatology and Dermatologic Surgery
  4. GA Orthopaedic Society
  5. GA Psychiatric Physicians Association
  6. GA Society of Ophthalmology
  7. The Georgia Society of Plastic Surgeons
  8. Epilepsy Foundation of GA
  9. Physicians for Fair Coverage (PFC) https://youtu.be/9euAeOm4b3g
  10. Georgia Society of Anesthesiology -- supporting efforts w/ advocacy but not a formal coalition member
  11. Georgia Radiology Society -- supporting efforts w/ advocacy but not a formal coalition member

- Fundraising:
  1. $100K from GCEP (including ACEP State Leg. grants, EMAF, ED groups and individuals) +
  2. $30K from MAG + ongoing $ and PR/GR support of PFC.

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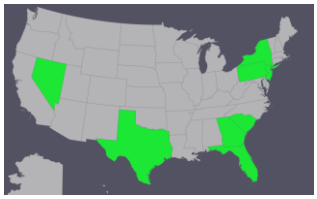
GA Case Study

- Expenditures:
  - Public relations (PR) and gov't relations (GR)—GCEP, MAG coalition and PFC
  - Paid media/online advertising
  - CQ and FB efforts have generated over 15K letters to Governor and Lt. Gov.
- Results? OON bill based on FH 80th percentile passes the GA Senate 52-0 and then was gutted 2 weeks later in the House.
- What would GCEP have done differently?
  - Started earlier w/ coalition and fundraising.
  - Not tried to amend existing law—used the PFC model legislation

ACEP Resources

- State Chapter Public Policy Grants
  - Georgia
  - Nevada
  - Texas
  - Pennsylvania
  - New Jersey
  - Florida
  - S Carolina
  - New York



- Harry Monroe & the State Legislative Committee

WA-ACEP and FCEP case study: Use the Free Media!

- Editorial Boards
- Letters to the editor
- News Articles
- Extended Interviews

Case study--FCEP Used RCM Data to Quantify the Issues:

The emergency physician sees an **average of $138,000 per physician in uncompensated care yearly** and is the Safety Net for all Florida citizens, including vulnerable uninsured, Medicare, Medicaid, and Pediatric patients.

EMERGENCY PHYSICIAN OUT-OF-NETWORK (OON) CHARGES:

Average Emergency Physician OON Charge is*	Insurers' typical average payment is*	Average patient payment of their $372 deductible, co-pay and balance bill is*	The 80th percentile charge for highest acuity EM visit is**
$679	$307	$49	$950

* Sample of 10% of FL ED visits, 2014-2015

BALANCE BILLING RESULTS FROM THE UNWILLINGNESS OF INSURERS TO CONTRACT FOR ADEQUATE PAYMENT FOR PROVIDERS, WHICH OCCURS FOR ONLY ABOUT 12% OF INSURED FLORIDIANS.

New ACEP Chapter OON Toolkit: March 2017

- Talking Points and Fact Sheets
- Legislative strategies, Principles and Proposed Solutions.
- ACEP/EDPMA Joint Strategies White Paper
- Model Legislation: CT and Physicians for Fair Coverage
- Legislative testimony and comment letters to various states
- https://www.acep.org/Advocacy/Chapter-Toolkit-on-Out-of-Network-Payment-Legislation/

NV case study

- Be prepared to work hard in the legislature.
- Prepare a Plan B.
- Move quickly and be nimble
- "It's easier to kill a bill than to pass one."

What's the solution? PFC & JTF OON Model Legislation

- MBS tied to a non-profit database of charges not tied to a health plan, e.g. FH
- Not limited to hospital based clinicians, nor to the usual "surprise billing" situation.
- Pt's in network and OON cost sharing should be the same.
- Health plan should reimburse the Pt cost sharing directly to the clinician.

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PFC & JTF OON Model Legislation

- OON balance billing banned for POS 23, provided health plans reimburse 80th percentile of Fair Health (MBS).
  - Clinicians may mediate if no MBS.
- OON balance billing banned for POS 21 (IP) and 22 (OP) unless Pt "opt out".
- Pt "opt-out" based on written notice 24 hrs in advance:
  - Notice and consent to OON charges.
  - Estimate of OON charges.

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PFC & JTF OON Model Legislation

- Mediation may be initiated by Pt and in very limited circumstances by the clinician.
  - Clinician may initiate mediation for higher reimbursement for "Gould" criteria.
  - Pt's in network & out of network cost sharing is the same—minimize impact on the Pt.
  - More time efficient for clinicians A/R & non-binding so litigation is an option if necessary
- No false/misleading EOB statements.
- Enforcement for non-compliance.

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AMA House of Delegates Resolution June 2017

2017 AMA House of Delegates Resolution #115

OUT-OF-NETWORK CARE

RESOLVED, that our AMA reaffirm Policies H-165.839, H-373.998, H-285.911 and H-285.908 (Reaffirm HOD Policy); and be it further

RESOLVED, that our AMA adopt the following principles related to unanticipated out-of-network care:
1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. A minimum coverage standard for unanticipated out-of-network services should be identified. The minimum coverage standard should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary being based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where the physician's unique background or skills (i.e. the Gould Criteria) are not accounted for within a minimum coverage standard. (New HOD Policy); and be it further

RESOLVED, that our AMA develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care. (Directive to Take Action)

- Introduced by ACEP, AAOS, ACR, ASA, CAP and delegations from CO, New England, GA, PA and WA
- AMA legislative arm is drafting model legislation based on our combined stakeholder model (we hope) .

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Final Comments and Resources

- ACEP, EDPMA & PFC have stepped up w/ staff, resources and support.
- Nat'l multi-specialty efforts should assist at the state level.
- PFC has been formed w/ sole focus w/ successful resolution of OON issues.
- Add 'l resources: expert panels, strategy documents and PR/GR expertise from PFC in 2017.

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Action Items

- Balance Billing and fair payment playing out state by state- Preserve the safety net
- Get involved! Stay Active! Be Known!
- Monitor your state's balance billing regulations
- Monitor dispute resolution results
- Advocate for a fair payment standard
  - 80th percentile of fair health
- Develop prospective ADR language
  - Include key elements

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Contact information:

Scientific Assembly WASHINGTON, DC 17

Ed Gaines, JD, CCP

Chief Compliance Officer,

Emergency Medicine Div.

Zotec Partners

Greensboro, NC

egaines@zotecpartners.com

919-641-4927

Follow me on Twitter:
@EdGainesIII

http://twitter.com/EdGainesIII

PFC BY THE NUMBERS

PFC PHYSICIANS FOR FAIR COVERAGE

A multi-specialty organization representing 13 major physician practices across 3 specialties with 63,000+ physicians in 42 states serving more than 50 million patients per year in 3,000+ facilities.

- **Founded: June 15, 2016**
  As a Non-Profit Non-Partisan Advocacy Alliance focused exclusively on Out-of-Network issues.
  Mission: To improve patient protections by ending the insurance coverage gap, promoting transparency, and increasing access to care.
  Model Legislation: Only organization to develop and introduce a multi-specialty approved legislative solution for use across all states.
  Public Relations: Campaign developed for state and federal use. "End the Surprise Insurance Gap"—websites, social media, TV ad, national survey of consumers/patients supportive of PFC position.
  Toolboxes and Coalition Playbooks: For state coalition development and deployment of PR and GR resources.
  NORC Report 2017: Reaffirms FAIR Health as the most effective benchmarking tool for out-of-network reimbursement
- **Establishing Partnerships** with 12 National Specialty Groups with official support from the American Medical Association and State Affiliate Specialty Groups in 9 states to date.
- **Consultants Hired: 2 Nationally renowned public and governmental relations firms plus state-based lobbyists in 7 states: GA, MA, NC, NJ, NV, OH, PA**
  Powell Tate: Creative development and deployment of scalable and customizable PR campaign
  The BGR Group: State strategic development and gubernatorial intervention in critical states
- **Staff Employed: 3 Highly Experienced and Proven Professionals**
  Staff members with extensive experience in state and national legislative campaign development and deployment; single focus professional staff is unique and unlike other organizations.
- **States with Campaign Activity:** 23
  Model language introduced, coalitions developed or developing, monitoring activities and/or campaigns deployed to advance model legislation or defeat "bad" legislation.
- **Physician Activists Engaged:** 2,000+
- **Consumer/Patient Grassroots Supporters Engaged: nearly 20,000**
- **Instrumental in 6 Key State Campaigns: GA, ID, NC, NJ, NV, OR**

Educational Appendix: PFC

http://thepfc.org/

https://endtheinsurancegap.org/

End the surprise insurance gap

The Campaign to End the Surprise Insurance Gap Recommends FAIR Health

The Campaign to End the Surprise Insurance Gap believes physician reimbursements for out-of-network care should reflect market conditions and should be based on independent and objective market information. In our view, FAIR Health constitutes an excellent and indeed unique source of data for determining such payments. FAIR Health, a data organization established to bring transparency and clarity to health care costs and health insurance information, maintains the largest collection of private insurance claims in the United States. It is a conflict-free, independent, national not-for-profit with a Board of Directors comprised of nationally recognized thought leaders. It uses its vast repository of almost 22 billion claims, growing by over one billion new claims annually, to create standard data products, custom analytics and consumer tools available to the entire healthcare sector.

- FAIR Health:
  - Continually receives claims data from 60 insurers and administrators
  - Captures approximately 75% of the privately insured population
  - Organizes data by procedure codes in 493 geozips nationwide
  - Produces benchmarks for all healthcare services based on 12 months of recent claims data
  - Applies rigorous auditing and validation process to all claims data
  - Is a highly secure, robust claims database and state-of-the-art technology
  - Does not allow data to be manipulated, supplemented or pre-edited
  - Staffed by experts who conduct all operations in-house
- It is one of only four qualified entity organizations recognized by the Centers for Medicare and Medicaid Services (CMS) and is entitled to receive all of CMS's Parts A, B and D Medicare Data.
- FAIR Health's consumer website was ranked the "Best Health Care Cost Estimator" on Kiplinger's Personal Finance 2016 Best List.
- In a 2014 report to CMS comparing data bases to establish payment rates for out-of-network emergency room services, NORC at the University of Chicago concluded that FAIR Health is "...the database best suited to help address CMS' concerns about establishing comprehensive and transparent out of network payment benchmarks."
- It has broad acceptance throughout the health care industry and its data support studies and solutions for:
  - The lack of transparency regarding the cost for out-of-network services
  - Changing reimbursement models
  - Access issues arising from low number of physicians in narrow health plan networks
  - Surprise billing
  - Reimbursement for medical services including emergency care
  - Fair, practical dispute resolution process

Appendix: The "Surprise Insurance Gaps" & Importance of Fair Health

https://youtu.be/9euAeOm4b3g

Appendix: Fair Health is officially endorsed by CCIIO's own consultants as the most transparent & verifiable database.

FINAL REPORT

Data Sources for Establishing Payment Rates for Out-of-Network Emergency Room Services

JUNE 26, 2014

PRESENTED TO: Eugene Freund, Center for Consumer Information and Insurance Oversight, Centers for Medicare & Medicaid Services, HHS

PRESENTED BY: NORC at the University of Chicago, Jon Gabel, Senior Fellow, 4350 East-West Highway, Suite 800, Bethesda, MD 20814-4499, (301) 634-9330 Main, (301) 634-9301 Fax, Gabel-Jon@norc.org

- "ACEP did provide CMS with documentation [of] recent issuer policy changes that have resulted in marked decreases in reimbursement for such [ED] services."
- CCIIO never released NORC report to ACEP…..
- Until CCIIO was sued by ACEP in May 2016.
- Findings and conclusions.

Appendix: NORC again endorses FH as the OON standard

FINAL REPORT – *Revised*

Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement

MAY 24, 2017

PRESENTED TO: Michele H. Kimball, President and CEO, Physicians for Fair Coverage, 8400 Westpark Drive, 2nd Floor, McLean, VA 22102

PRESENTED BY: NORC at the University of Chicago

AUTHORS: Jon Gabel, Luke Hill, Leanna Moron, Aaron Wesolowski, Heidi Whitmore

NORC at the UNIVERSITY of CHICAGO

Overall, this review showed that FAIR Health, HCCI, and state APCDs are important potential sources of data for the minimum benefit standard policy use case.[8] It should also be said that Truven and BHI also may have data relevant to this use case, depending on the state and geographic area. However, both of those organizations noted that they do not license their data for public benchmarking, and we did not find examples of arrangements either organization has with government entities for benchmarking.

Based on our research, Fair Health is the only vendor whose data are being used for the specific purpose of establishing reimbursement standards for out-of-network services in more than one state and who

FINAL REPORT | 2

NORC | Qualitative Assessment of Databases for Out-of-Network Physician Reimbursement

currently make their data available for this purpose broadly across the United States. As a pragmatic matter, this may be the most important consideration.