SUBJECT: Mediation of out-of-network health benefit claim disputes

COMMITTEE: Insurance — committee substitute recommended

VOTE: 8 ayes — Smithee, Martinez Fischer, Eiland, Hancock, Hunter, Isett, Taylor, Thompson

0 nays

1 absent — Deshotel

WITNESSES: For — Jerry Stamps, North Richland Hills Baptist

Against — Patrick Giam, Greater Houston Anesthesiology, P.A.; Michael Hicks, Pinnacle Partners in Medicine, P.A.; William Hinchey, Texas Medical Association; Jeff Jekot, Texas Society of Anesthesiologists; Greg Karnaze, Texas Radiological Society, Austin Radiological Association; Sam Roberts, Texas College of Emergency Physicians; William Schlotter, Capitol Anesthesiology Association, Texas Medical Group Management; Ezequiel Silva, Texas Radiological Society, South Texas Radiology Group; Michael Stanley, Pediatrix Medical Group Texas; Susan Strate, Texas Society of Pathologists; Dan Stultz, Texas Hospital Association; Jared Wolfe, Texas Association of Health Plans; (*Registered, but did not testify:* Susan Baer, Clinical Pathology Associates, P.A.; Ronald Booker, Greater Houston Anesthesiology, P.A.; Cheryl Conner, Emergency Service Partners; Robert Connor; David Marwitz, Texas Dermatalogical Society; Joe Monk, Texas Society of Anesthesiologists; Jaime Ronderos, Pinnacle Partners in Medicine; Mark Silberman, Clinical Pathology Associates)

On — (*Registered, but did not testify:* Jay Thompson, Texas Association of Life and Health Insurers)

BACKGROUND: A preferred provider benefit plan may reimburse health care providers in the plan's preferred provider network at a different rate than the plan reimburses out-of-network health care providers. Health benefits for state of Texas employees may be provided through a health maintenance organization (HMO) or through an arrangement in which patients pay different rates for in-network and out-of-network providers.

DIGEST:

CSHB 2256 would allow enrollees of preferred provider benefit plans or of a Texas employee health benefit plan that was not an HMO to request mediation of an out-of-network claim settlement if:

- the amount for which the enrollee was responsible for payment to a facility-based physician after copayments, deductibles, and coinsurance was greater than $500; and
- the facility-based physician provided the service in a preferred provider hospital or a hospital that contracted with the health plan administrator.

Facility-based physicians would include anesthesiologists, pathologists, radiologists, emergency physicians, or neonatologists that provided services to patients in a facility under which they had been granted clinical privileges. A facility-based physician would not be required to mediate an enrollee's billed charge if the patient had signed a disclosure from the physician that explained the amounts for which the enrollee could be responsible.

Participation in mediation. Both the insurer and facility-based physician would be required to participate in the mediation if this signed disclosure had not been obtained. The insurer or physician could be issued an administrative penalty for bad faith mediation, which would be constituted by behaviors such as failing to participate in the mediation or provide certain information to the mediator. The enrollee or enrollee's representative would not have to participate in the teleconference or mediation for mediation to proceed.

Dispute resolution procedures. The bill would define the process by which the enrollee would request mediation from the Texas Department of Insurance (TDI) and how the insurer and physician would be notified of the request. The facility-based physician could not pursue collection of the bill once request for mediation was received.

The parties to the mediation would be required to participate in an informal settlement teleconference to attempt to settle the dispute before mediation. If the teleconference was not successful, mediation would proceed by consent of the enrollee.

The mediation would be conducted by a mediator agreed upon by all parties or appointed by the chief administrative law judge by random assignment. A mediation could not exceed four hours unless agreed upon by all parties. Each party would have the opportunity to state the party's position. The mediation would consider whether:

- the amount charged by the facility-based physician was excessive;
- the amount paid by the insurer for the service was the usual and customary rate or was unreasonably low; or
- the amount for which the enrollee would be responsible would be excessive.

If the mediation was not successful, the chief administrative law judge would refer the matter for trial by a special judge. The parties would pay a proportionate share of the special judge's fee. The special judge's verdict would proceed according to the established procedures of Civil Practice and Remedies Code, ch. 151.

The mediator would prepare a confidential mediation agreement and order that stated the total amount for which the enrollee would be responsible to pay the facility-based physician and any agreements made between the insurer and physician.

Additional remedies. The remedies provided by this bill would be in addition to any other defense, remedy, or procedure provided by law. The enrollee could file a complaint with the Texas Medical Board for improper billing or with TDI for unfair claim settlement practices. These entities would adopt rules regulating investigation and review of complaints related to settlement of an out-of-network health benefit claim. TDI and the Texas Medical Board would maintain information on each of these complaints, on any related mediation, and on the claim upon which the complaint was based.

Insurer requirements. The insurance commissioner would adopt rules for network adequacy standards adapted to local markets in which a preferred provider benefit plan operated. An insurer would submit to TDI the methods by which the insurer computed out-of-network reimbursements under preferred provider benefit plans and the effect these methods had on the insureds' out-of-pocket costs.

Provider disclosures. A facility-based physician who provided services out-of-network to an insured would have to notify the patient of the mandatory mediation process. A health care facility would provide to patients a contact list of all facility-based physicians with privileges at the facility and would inform patients that these physicians could bill them for amounts not paid by their insurer.

The bill would take immediate effect if finally passed by a two-thirds record vote of the membership of each house. Otherwise, it would take effect September 1, 2009. The bill only would apply to health benefit claims filed on or after this effective date.

SUPPORTERS SAY:

CSHB 2256 would provide health insurance consumers recourse to dispute balance billing practices by establishing a mediation process in which patients, insurers, and health care providers could agree upon fair payment of certain out-of-network medical charges.

Insurers often set a maximum allowable cost for out-of-network medical services. They calculate the amount of coinsurance that the patient would owe for the out-of-network procedure based on the maximum allowable cost. When the amount charged by an out-of-network provider exceeds the maximum allowable cost, the patient is "balance billed" for this difference in addition to paying coinsurance. This can leave patients with unexpectedly high medical bills and no recourse. Insurers will claim providers have charged too much while providers will claim insurers underpaid for their services.

CSHB 2256 would allow health consumers to initiate a mediation process when their out-of-network charges exceeded $500. There are many instances in which consumers have tried to avoid out-of-network services but have been balance-billed despite their efforts. For example, a patient could see an in-network surgeon for a procedure but the facility could schedule an out-of-network anesthesiologist to attend the surgery. Further, patients diligently could check that all services they were to receive would be performed by an in-network specialist, but unbeknownst to patients, their lab results could be sent for review by an out-of-network practitioner.

Patients also may be harmed by balanced billing due to the practices of the insurer or provider. Some providers intentionally avoid contracting with any health plans yet accept positions with busy health care facilities so that they are assured referrals through which they can bill high service charges

because every patient they see will be out-of-network. In addition, many insurers set the maximum allowable cost they use to calculate payment for out-of-network services much lower than the amount they have negotiated to pay in-network service providers. This can make insurer reimbursement rates artificially low for out-of-network providers, which shifts more costs to the health consumer.

The mediation option established by CSHB 2256 would provide the most fair and effective resolution for balance billing issues for all parties. It would require the participation of the insurer and provider so the charges billed by the provider as well as the amount reimbursed by the insurer could be reviewed and subject to negotiation. The $500 threshold that a patient's out-of-network charges must exceed to initiate mediation would ensure the parties were not drawn into mediation for charges that did not impose an unreasonable burden on a consumer. There would be several points during the conflict resolution process at which an agreement could be reached. The parties would have an incentive to negotiate because the sooner in the process that an agreement was reached, the less costs would be incurred by the mediation participants.

The bill would establish other consumer protections standards. DSHS would be required to establish provider network adequacy standards for state employee health plans and preferred provider organizations. This would decrease the likelihood that a consumer was forced to see an out-of-network provider and could incur higher medical bills. The standards would be adapted to the unique local health care market so insurers would not be required to meet unreasonable standards for participating providers if they were in a smaller market.

Further consumer protections would include the requirement that preferred provider benefit plans would have to provide TDI information regarding the methods used to compute out-of-network reimbursements such as maximum allowable amounts. Patients also would receive lists of out-of-network doctors when they were admitted to a hospital.

Consumers still could go through their insurer's grievance process and could file complaints against insurers with TDI and against health care providers with the Texas Medical Board. Being able to pursue a complaint with the Texas Medical Board in addition to engaging in the mediation process would be critical, because certain medical practitioners deserve further reprimand for charging exorbitant fees.

Other alternatives to address billing issues would not be as effective or appropriate as the mediation process in CSHB 2256. Facilities and physicians already are required to provide estimates of charges for certain non-emergency procedures upon request by a patient. Any more extensive transparency requirements, such as requirements for providers to post their service charges, could lead more providers to increase their charges to amounts they recognize other providers have been able to obtain for the same services. Imposing further regulations on health insurers regarding how much they must reimburse out-of-network providers would put insurers at a competitive disadvantage in negotiating contracts with potential network providers.

OPPONENTS SAY:

CSHB 2256 should not require providers and insurers to engage in a mediation process initiated by a consumer regarding balanced billing concerns. The consumer would have nothing at stake in requesting expensive mediation regarding any eligible out-of-network charges they were billed because the insurer and provider would split the cost of the mediation process and the consumer would have no penalty for failing to attend the mediation. This mediation process would cost time and money to insurers and providers when it is possible that neither of these parties acted inappropriately with respect to the patient's claim. A better approach to consumer balance billing issues would be to target policies to curb inappropriate practices engaged in by either the insurer or provider.

Often doctors will charge the insured significantly lower amounts than they charge to out-of-network patients. Lower charges to those with health insurance are justified by the discounts insurers can obtain from the quantity of business insurers provide to doctors. If a health consumer truly has been overbilled or excessively charged by a provider, other approaches would be preferable to mediation. If health pricing were made more transparent by requirements that health providers make public the prices they charge for services, consumers could research more effectively the amounts they would be charged by out-of-network providers. In addition, patients currently may file a complaint with the Texas Medical Board against any doctor that the patient felt was price gouging. The board can and has sanctioned physicians for excessive charges.

Revisions could be made to insurer practice as well. Insurers should be required to calculate the enrollee's coinsurance owed for an out-of-network service based on the amount charged by the provider and not based on the maximum allowable cost established by the insurer. This

would reduce the consumer's share of costs. Consumers are led to believe they pay more for their premiums in a preferred provider organization to get out-of-network coverage and that these higher premiums would reduce their long-term, out-of-pocket costs. Requirements also should be instituted for the timeframe in which insurers must update changes to their list of in-network providers.

Preferred provider organizations never should charge out-of-network rates for emergency services. Insurance enrollees in need of emergency services have no choice but to seek treatment at the closest emergency facility.

Avoiding the conflict resolution approach proposed by this bill also would avoid the negative impact to general revenue funds of $11.5 million during the biennium with costs increasing in subsequent years. The Employees Retirement System has worked hard to reduce administrative costs, and this bill would increase these costs due to mediation participation and settlements.

NOTES:

The fiscal note indicates a cost to general revenue funds from the CSHB 2256 of $11.5 million during fiscal 2010-11. These costs would be incurred by the Employees Retirement System as a result of increased administrative costs due to the mediation process and increased claim payments as a result of mediation.