Are you **Ready** for the **Out-of-Network** Law?

Presented by:

John D. Fanburg, Esq.

Mark Manigan, Esq.

Keith J. Roberts, Esq.

Insurance Plans Affected by the Act

- Plans subject to law
  - Non-ERISA health benefits
  - State health benefits program
  - School employees health benefits program
- ERISA plans may opt-in/ERISA members have rights
- Plans excluded under law
  - Medicaid/Medicare/Medicare Advantage
  - Accident-only, credit, disability, long-term care
  - Tricare, Federal employees
  - Workers compensation, PIP, auto med pay

Out-of-Network

Consumer Protection, Transparency, Cost Containment, and Accountability Act (the "Act")

- Effective August 30, 2018
- Intended to avoid "surprise" to consumers and control costs of OON benefits
- Broad notice requirement to all health care providers where a covered person may get OON services and be billed at OON rates
- Arbitration to resolve reimbursement disputes arising from emergent/urgent/inadvertent
- Penalties for waivers and other violations
- Subject to regulatory process

Medical Services Affected by the Act

- Notice provisions:
  - Affects all non-emergent care
- Arbitration for OON reimbursements
  - Only emergency & inadvertent services
- ***Not*** Covered by OON Law
  - Knowing, voluntary, and specific selection of OON provider by patient where patient could have chosen in-network services

Health Care Facility Disclosures: Non-Emergent Care

- Prior to scheduling an appointment:
- **All facilities** shall:
  - Disclose network status IN/OUT
  - Advise patient to check with physician (OON services)
- **In-network facility** shall:
  - Explain in-network financial responsibilities
  - No further costs, unless knowing OON services
  - Report any violation of Act to carrier/government
  - Advise self-funded plans may that have not opted in may result in OON services fees; and person should contact plan sponsor for details

Health Care Facility Disclosures: Non-Emergent Care

- **Out-of-network facility** shall:
  - Advise facility is OON
  - Services may be provided on OON basis at facility
  - Associated services may be OON (anesthesia, lab, pathology)
  - Costs may exceed that covered by plan (ded/co-pay)
  - Patient may have financial responsibility to pay
  - Person should contact carrier for cost consultation

Health Care Facility Disclosures: Non-Emergent Care

- **All facilities** shall:
  - Make standard charges available to public
  - Website posting to include:
    - Plans that the facility is participating in
    - Physician fees not included in facility fee
    - Physicians may or may not participate in plans
    - Person should check with physician for benefits
    - Person should contact carrier for consultation
    - Contact info for associated hospital groups
    - Contact info for facility-employed physicians who participate in plans

Health Care Facility Disclosures: Non-Emergent Care

- **All facilities** shall:
  - Advise in any change of network participation status after appointment made but prior to time of service
  - Department of Health shall specify in further detail content and design of disclosure forms for all facilities

Health Care Professional Disclosures: Non-Emergent Care

- Healthcare Professional means an individual acting within scope of licensure that provides a covered service as defined by the plan

  - Prior to provision of services:
    - At time of appointment disclose plan participation
    - Verbally or in writing

  - If ***not*** participating, then prior to a procedure
    - Estimate costs to person
    - Provide CPT codes and charges that as foreseen by HCP
    - Advise person that OON financial responsibility applies
    - Advise person to consult insurance carrier on costs

Health Care Professional Disclosures: Non-Emergent Care

- A health care professional who is a ***Physician*** shall:
  - Provide, to extent available, contact information for any health care provider scheduled to perform in-office anesthesia, radiology, pathology or assistant surgery in connection with care of person
  - Contact information provided to person for referral of the person to a health care provider for coordinated care by the physician
  - Provide instructions to person on how to determine the participation status of of the health care providers and advise to contact carrier for consultation

Health Care Professional Disclosures: Non-Emergent Care

- A Physician shall:
  - Provide, for scheduled facility admission, contact information for any other physician whose services will be arranged by the treating physician and information as to how to determine anticipation status and to contact carrier for consultation on associated costs
  - Notify person of any change in network participation status before service is provided
  - Primary care physicians/internists may provide verbal notice for unscheduled in-office procedures at time of service

Health Care Professional Disclosures: Non-Emergent Care

- Regulatory action:
  - Appropriate professional licensing boards shall regulate the content and details of disclosure forms
  - Disciplinary action for violations of the Act will also be regulated by the licensing boards

Facility Emergency Services

- Any health care facility shall not bill the person in excess of any applicable deductible and co-pay for IN-network services as per plan
- IN-network facilities shall notify all physicians of plan participation and provisions of this Act.
- OON facilities that bill in excess of plan allowance that are not able to reach agreement with carrier may pursue binding arbitration.
- Self-funded plans may elect to adopt Act provisions

Facility Inadvertent Services

- Person receives, on an emergent or urgent basis, inadvertent OON services, then:
  - The health care professional performing shall:
    - Not bill person in excess of co-pay/deductible
    - Arbitration process applies to reimbursements
    - Self-funded plans may elect to adopt Act provisions

Arbitration Timeline

- Claim received by carrier
  - Emergency/urgent and inadvertent OON bills
- 20 days later – Carrier must pay or inform provider that bill is excessive, or partially pay bill
- Within next 30 days – Parties negotiate bill
- Within the next 30 days, the Carrier, Provider, or Patient may initiate binding arbitration
- Self-funded plans may elect to adopt Act provisions

Arbitration Procedure

- Party requesting arbitration shall notify other party of final offer prior to arbitration
  - Carrier's offer must be the paid amount
- Parties' final offers must be at least $1,000 apart
- Binding arbitration is initiated by request to Department of Banking and Insurance (DOBI)
  - DOBI will contract with an entity that has experience in health care pricing arbitration
  - HCAPPA applies in interim (MAXIMUS)

Arbitration Process & Awards

- Parties will make written submissions to arbitrator
- Within 30 days of request, arbitrator shall issue a baseball-style award
  - Arbitrator selects one of the party's final offers
- Arbitrator fees and costs – split by parties
  - Exception where arbitrator finds the carrier's final offer was not made in good faith
- Parties responsible for their own costs including legal fees
- Excess payment by carrier, if any, to be made within 20 days, without interest, until 20 days post award

Arbitration Limitations

- Preauthorization and review requirements of the plan, as applicable, must be followed to invoke arbitration
- A person who knowingly selected OON benefits is not able to invoke arbitration
- Self-funded plans either opt in; OR
- Plan member may initiate to seek a binding ruling on fee exposure with a nonbinding recommendation to the self-funded plan, member fees may be waived
- DOBI to establish the process for both scenarios of Act application to OON disputes

Additional Act Provisions

- Robust database to be created for arbitration
- Waiver is a violation
  - Knowingly and/or for inducement of OON benefit
  - Safe harbor exceptions apply to waiver
- Violations
  - Facility or Carrier $1,000 per violation, per day, $25,000 per occurrence limit
  - All others $100 per violation, per day, $2,500 per occurrence limit

Questions?