Three Ways Self-Insured Plans Can Leverage State Laws to Protect their Members from Balance Billing

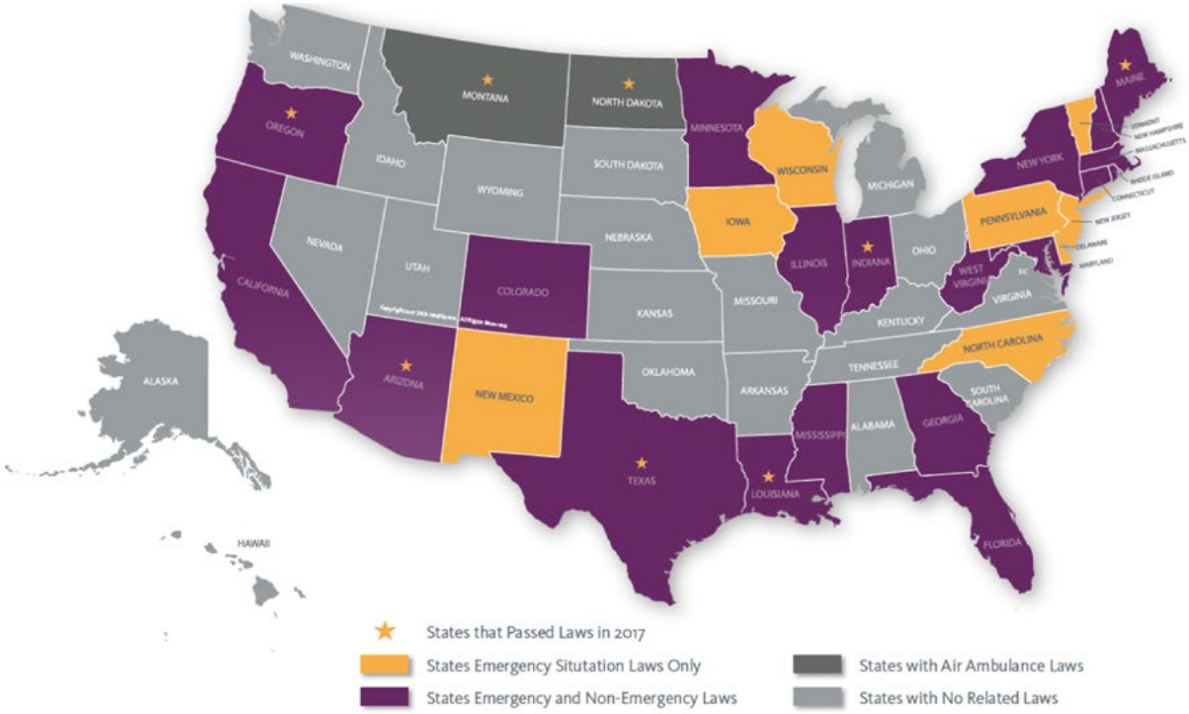
By Matthew Albright

Nearly everyone has a personal or professional horror story about an egregious balance bill for healthcare services, but, while many state laws have provisions meant to protect patients from balance billing, there appears to be no legislation at either the federal or state level that protects members of *self-funded health plans* from balance bills.

A balance bill occurs when a provider sends a patient a bill for the difference between what the patient's health plan has paid and what the provider charges, and these bills can be costly when the provider is outside of an insurer's provider network.

A "surprise" balance bill, a bill from an out-of-network provider that the patient did not know was out of network, can have an especially significant and unexpected impact on a patient's financial well-being. Most commonly, these surprise bills come from situations that are beyond a patient's control; for instance, when healthcare is provided in an emergency situation or when an out-of-network physician provides services in an in-network hospital.

The issue of egregious balance billing is growing on a number of fronts: First, according to a 2016 study by the National Academy for State Health Policy, statistics demonstrate that the frequency of surprise balance billing is increasing. Second, the charges on balance bills appear to be increasing as well, according to a report by The Schaeffer Initiative for Innovation in Health Policy.



Fortunately, public and political attention on surprise balance billing is increasing as well. Last year, over eighty bills were introduced by state legislatures on the issue and, ultimately, eight states passed laws. A total of twenty-eight states now have at least a minimum of provisions intended to mitigate balance billing by out-of-network providers in the emergency context and/or surprise billing in non-emergency settings. (See map.)

Increased balance billing and egregious out-of-network claims negatively affect members of both fully-insured and self-insured ERISA plans. However, self-insured health plans have a particular concern with balance billing since member satisfaction has a greater impact on their business model. In general, it appears that most state laws on balance billing and reimbursement for out-of-network providers do not apply to self-insured health plans either because of how the law defines the payer or because the requirements are arguably preempted by ERISA. On closer look, however, this is not always the case.

Some state laws do include elements that can provide support for self-insured ERISA plans that want to advocate against the balance billing of their members, especially if the plan includes provider negotiations as part of its cost management strategy. In addition, some state laws may help self-insured ERISA plans negotiate a provider down to a reasonable reimbursement rate overall, even if the law does not apply directly to self-insured health plans.

Listed below are three tactics, using specific state laws, which self-insured health plans can use when working with providers to both protect members from balance billing and keep the cost of out-of-network bills low.

1. Find state law provisions that may apply to self-insured.

While there are some federal laws that address out-of-network provider reimbursement (more on that later), there is nothing in ERISA or any other federal law that prohibits balance billing. Many states, on the other hand, do have laws that prohibit balance billing, put floors on out-of-network reimbursement rates, and require providers to give notice to patients that their healthcare may be provided by out-of-network providers. In these categories of requirements, nuggets of leverage for self-insured health plans do exist. A good example of this is the balance billing law in Oregon, HB 2339, passed in 2017, which prohibits out-of-network providers from balance billing members for emergency and non-emergency health services.

The Oregon law addresses the question of ERISA preemption up front by stating that the law does not apply to any plan "that is exempt from state regulation" because of ERISA. However, ERISA preemption likely does not apply here, because the Oregon requirements apply to *providers* only. Providers, in network or not, have no direct standing under ERISA. The Oregon law does not include any requirements that apply to plans in the law, so there appears to be no conflict with ERISA. We might expect more laws like this:

A bill proposed in Kentucky for the 2018 legislative session, KY SB 79, uses similar language in its balance billing prohibition.

ERISA preemption is not automatically triggered for every state law that regulates healthcare. Some state laws regarding balance billing, depending on how they are structured and how their terms are defined, may be applicable despite ERISA preemption. The Oregon law and similar laws might be contested in court in the context of an ERISA preemption case, but to the extent that these laws are helpful in protecting the member and negotiating reasonable out-of-network reimbursements, self-insured plans should utilize them.

2. Use state laws as starting points to protect members from balance billing and for setting reimbursement "floors."

Protection from balance billing of emergency and nonemergency services

Of the 28 states with some balance billing provisions, 25 include a provision that prohibits a patient from being balance billed, and 18 of those have balance billing prohibitions in the non-emergency context. The laws vary in applicability. Four of the states have balance billing prohibitions that apply only to HMOs. Others, like New Jersey, New York, and North Carolina, clearly put the responsibility on the payer to make the provider whole, while still others, like Illinois and Maryland, apply only to specific types of providers.

Again, for the most part, these balance billing prohibitions do not clearly apply to the self-insured member or plan. However, reminding a provider that its state has a balance billing prohibition is still a good place to start at the negotiation table for a self-insured health plan.

The intention of these laws is to mitigate egregious balance billing claims for the states' citizens. Although the provider may be knowledgeable enough to know the difference in the law between self-insured and fully insured members, starting the discussion with the state's balance billing prohibition creates a baseline from which the negotiations can start.

Further, in some cases, such as New York, the dispute resolution process applies to members of self-insured ERISA plans. That is, a member of a self-insured health plan can involve a provider in a dispute about both emergency and non-emergency egregious surprise bills.

Research has shown that providers perceive that state-level reviews will not go in their favor, and they perceive that they'll get a better deal by negotiating with the payer. In other words, sometimes just the possibility of a dispute with a member may bring the provider to an agreement.

Reimbursement "floors" for out-of-network non-emergency claims:

Note that, in most states, the Affordable Care Act's (ACA) 3-part minimum reimbursement rule applies to self-insured health plans for out-of-network emergency services. The ACA requires reimbursement "at least equal to" the greatest of three calculated rates:

1. The median amount for in-network providers for the emergency service;
2. The amount the plan uses to determine payments for out-of-network providers; OR
3. The Medicare amount.

Although the Centers for Medicare & Medicaid Services (CMS) has clarified that its rules do not prohibit the provider from balance billing the member after the payer has met this reimbursement requirement, the 3-part minimum reimbursement rule creates a low enough standard for most payers to get providers to the bargaining table.

Laws in 25 states have paired prohibitions on balance billing with requirements on what insurers must reimburse providers for out-of-network bills. Although the ERISA preemption is likely to apply in these states, there are two reasons why self-insured ERISA plans should counter any egregious bills by mentioning the "floor" of their state reimbursement provisions:

First, the provider is likely familiar with its state's balance/surprise billing reimbursement provisions and therefore the provider would likely expect to start with the state's "floor" with any reimbursement negotiation.

Second, these reimbursement provisions reflect what the state believes is fair for out-of-network providers to get paid in general. It is therefore not unreasonable for plans to start payments or negotiations with providers at these "floors."

Self-insured health plans may find reimbursement provisions in states like Florida, Maine, Iowa, and others to be useful, at least for emergency services. Maine's LD 1557, passed in 2017, allows payment rates at the average network rate, unless the provider and plan agree otherwise. Florida requires the lesser

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of billed charges, usual and customary rate (UCR), OR a negotiated rate. Iowa requires reimbursement to be the same as if the person had been treated by an in-network provider.

Reimbursement provisions in other states like Connecticut and Maryland are generally not payer-friendly or are too complicated to be useful, but they may still be helpful in cases of egregious billing if a plan wants to dig into the details. Connecticut, for example, uses the 80th percentile of FairHealth rates as its payment "floor." Maryland's out-of-network reimbursement provisions are payer and consumer friendly overall, but the algorithms for figuring out the "floors" for three difference categories of providers are complicated and not easily explained in a negotiation setting.

3. Follow up on Required Provider Notices

State laws are increasingly concerned with notice from providers and consent from patients before out-of-network services are provided. Eight states now require providers to give notices to patients about possible out-of-network charges for nonemergency services, and half of these laws were passed in 2017. Depending on how they are written, these notices may require providers to give notices to members of self-insured ERISA plans.

New York is a good example where hospitals and physicians are required to notify – both in writing and verbally at the time an appointment is scheduled – patients seeking non-emergency care of the health care plans with whom they participate. New York's definition of "health care plans" includes self-insured health plans, and a provider notice by itself doesn't trigger ERISA preemption.

As with reimbursement provisions, even if the law is clear that these notice requirements are not being applied to self-insured members, there is an expectation that providers are giving these notices in all other cases. If they are not, it provides a beginning argument for not accepting an egregious bill.

Conclusion

Although ERISA preemption usually keeps self-insured health plans from worrying about state laws, many states have laws or will soon pass laws that put state government and self-insured health plans on the same side of the balance billing issue. Read your state laws closely and use those that do not trigger ERISA preemption to protect your members from balance billing. Use your state's balance billing prohibitions and reimbursement "floors" as starting points for out-of-network reimbursement. When you make state laws on balance billing a part of your out-of-network reimbursement strategy, you're helping both members and your bottom line. ■

Matthew Albright currently serves as Chief Legislative Affairs Officer at Zelis Healthcare where he tracks emerging legislation on EFT healthcare payments, provider network adequacy and access, and claims auditing and editing. Previously, he was Director of the Administrative Simplification Group for the Centers for Medicare & Medicaid Services (CMS) where he drafted regulations and developed policy in accordance with Affordable Care Act mandates.