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OUT OF NETWORK PROVIDER PAYMENT AND BALANCE BILLING UNDER THE PATIENT PROTECTION AND AFFORDABLE CARE ACT

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One of the most common issues we encounter between providers and payors is how the provider should be paid for treating a patient who is covered by a health plan that doesn't have a contract with the provider. We've previously written about it here, in the context of insurers' controversial use of the Ingenix database to calculate usual and customary rates, and here, in the context of a report issued by the Senate Commerce Committee detailing the affect these underpayments have on consumers who are billed the remaining balance.

This article discusses the issue in the context of the Patient Protection and Affordable Care Act (PPACA), the health care reform legislation signed by President Obama in March of this year. One of the lesser known provisions of this legislation requires Health and Human Services (the "Department") to implement rules addressing the amount to be paid to out of network providers who provide emergency services. The Department proposed its interim final rules in the Federal Register on July 28, 2010. According to the interim rules, which took effect August 27, 2010, health plans must cover emergency services without requiring pre-authorization, and they must reimburse the provider the greater of (a) the median in-network rate, (b) the usual and customary rate, calculated using the plan's formula, or (c) the Medicare rate.

The Problem

This is an important development for healthcare providers, health plans, and patients. In the absence of Federal law on point, the parties were forced to look to state law to determine who should be responsible for reimbursing the provider under these circumstances and how much should be paid. Unfortunately, state laws addressing these circumstances vary greatly, if they exist at all.

Some states have no laws addressing the situation, in which case the health plan will pay nothing, leaving the provider and the patient to fight amongst themselves about how much should be paid. This creates problems for the provider, who must hope that payment is collectable from the individual patient. It also creates problems for the patient, who assumed his or her services would be covered, and who is now stuck with a bill that is usually much higher than the amount the insurer would have paid, and often more than the patient can afford, leading to poor credit and/or Bankruptcy.

Other states have laws addressing how much the health plan should pay the provider. For instance, in Florida the health plan is required to reimburse the provider the lesser of the provider's charges (which are often significantly higher than the amount paid by contracted health plans), the agreed upon rate (which almost never exists), or the usual and customary rate, pursuant to Fla. Stat. § 641.513(5). This does not afford the provider a complete remedy, because the state law in question may be preempted by ERISA with respect to health plans obtained by the patient through his or her employer, and because even if the law is not preempted in a given case, it does not provide a minimum reimbursement amount, leaving the health plan with the option to unilaterally calculate the usual and customary rate in the manner most consistent with its own interests and thereby underpay the provider. [Aside: there is a bevvy of litigation concerning the appropriate method for determining the usual and customary rate, in the context of

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Workers' Compensation, Personal Injury Protection, and in this scenario; we are in the process of compiling this authority and publishing it separately, but opinions are fashioned faster than we can comment on them. See Baptist Memorial Hospital-Desoto, Inc. v. Crain Automotive, Inc., No. 08-6094 (5th Cir. 2010), which was decided while this article was being drafted. The usual and customary rate calculation was at issue in that case the context of an ERISA-governed plan. The court held that a plan administrator abused his discretion in making a determination of the usual and customary rate without a sufficient factual basis, which should include more than just a comparison to other claims received by the plan.]

However, many states with laws similar to this one don't prohibit balance billing for out-of-network providers, meaning the patient is left to pay the difference after the plan pays according to the statute. See this chart for a list of the many different state laws.

This creates an unacceptable uncertainty of terms between healthcare providers, health plans, and payors. Providers and payors are required to implement state-specific policies with regard to balance billing and payment rates (which can be costly). And patients are required to be intimately familiar with their plan documents, to ensure in advance that all providers from whom they seek treatment are in network, or to obtain the provider's charges in advance of treatment (which is impossible).

The Proposed Solution

The interim final rules propose to eliminate some of the uncertainties discussed above by setting forth a minimum amount that must be paid to an out-of-network provider for emergency services- the Medicare rate, and by providing for additional payment when either the usual and customary rate or the median in-network rate exceeds the Medicare rate. According to the Department, these regulations will significantly increase the amount health plans will be required to pay when their members go to the emergency room at a non-contracted facility, which will reduce the amount the patient is responsible for. The regulations, which do not apply to grandfathered health plans under PPACA (as discussed in this CRS Report), have already taken effect.

Remaining Issues

The interim rules set a minimum payment amount (the Medicare rate), but they do not eliminate the uncertainty associated with the usual and customary rate. First, by the language of the rules, the health plan is still charged with sole discretion to calculate the usual and customary rate, which will upset providers, who have considered themselves victims of underpayments by health insurers (i.e. Ingenix) for quite some time. See this letter filed by the American Hospital Association in opposition to the interim rules, which also argues that by setting a rate, the Department has eliminated the health plan's incentive to contract with providers. Additionally, and most important to consumers, the interim rules do not prohibit balance billing, which will still leave patients unexpectedly footing a substantial bill (albeit a little less than what they would be paying otherwise); and there remains doubt as to whether PPACA's express allowance of balance billing preempts state laws to the contrary. If so, the interim rules represent a step in the wrong direction for patients residing in states like California.

If nothing else, the above shows that without additional guidance, providers, payors, and patients should expect to continue to litigate out-of-network claims on an individual basis, notwithstanding the interim rules. If you would like to retain the services of an agency or attorney in connection with an issue you currently face, please feel free to contact Medical Accounts Systems or Jorge M. Abril, P.A.