HEALTHCARE BUSINESS MANAGEMENT ASSOCIATION

HBMA FRAMEWORK FOR OON BILLING LEGISLATION

The HBMA Out-of-Network (OON) Billing Task Force developed a four-part framework to help the HBMA GR Committee assess federal or state legislation on "surprise" unexpected OON medical bills. This document is also intended to serve as the basis of an HBMA response to media inquiries, communications with policy makers, and other opportunities for HBMA to respond to this issue publicly. The Framework was reviewed and approved by the HBMA Government Relations Committee on April 9. The Framework was reviewed and approved by the HBMA Board of Directors on April 11, 2019.

I. Definition of "Surprise" OON Scenarios.

There are many ways to look at the idea of a "surprise" medical bill. New policy proposals typically define "surprise" scenarios as out-of-network care delivered at an in-network facility. State laws vary in scope in terms of the types of scenarios they consider "surprise." Some are limited to just emergency services while others are broader. In general, most definitions of what constitutes a surprise billing scenario fail to recognize that health plan coverage policies contribute to surprise bills as well. The HBMA GR Committee believes surprise billing scenarios should be defined as:

- When an insured patient receives care from an emergency department for an emergency service by an emergency care provider who is out-of-network. Emergency services should not be limited to patient stabilization. Emergency services should include immediate follow up care related to the initial emergency;
- When a patient receives anticipated care at an in-network facility from an in-network provider and is not notified in advance that they may receive ancillary services provided by an out-of-network provider; and
- When a health plan denies coverage for an in-network emergency service for which a patient sought emergency care under the "prudent layperson" standard or for which the patient sought emergency care at the advice of another healthcare provider.

II. Preserving the ability of physician practices to negotiate fair terms of network participation with health plans.

Federal or state legislation must recognize and respect the ability of physician practices to negotiate fair network participation terms with health plans. Network participation terms include reimbursement rates as well as clinical and administrative requirements.

- Federal and state legislation should not establish a reimbursement rate for unexpected OON situations.

- Federal and state legislation should not require contracted practices to align their networks with their facility's networks.
- Federal and state legislation should not reimburse the facility under a "global" arrangement for unexpected OON situations.
- Any policy that relies on a binding arbitration system to resolve the OON reimbursement must require the arbiter to consider a rate that reflects the market value of the service if it were in network. Arbiters should therefore be required to consider a reasonable percentage of market rates (e.g. 80% of FAIR Health) in addition to what each party submits to the arbiter.

III. Patient Responsibility.

The HBMA GR Committee believes that patients should be protected from unexpected OON medical bills. For defined "surprise" billing scenarios, patient out-of-pocket responsibility should be limited to their cost sharing obligation if the unexpected OON service was provided to the patient in-network. However, new policies should recognize that patients are typically balance billed because their health plan offers poor coverage. A federal or state law that limits patient cost sharing in unexpected OON scenarios should also proactively strengthen insurance coverage requirements. New policies should also emphasize the role facilities play in preventing unexpected OON medical bills through practices such as patient notification and supporting practices in their efforts to negotiate fair network participation terms with health plans.

IV. Increase the responsibility of health plans to solve this issue.

Federal or state legislation should include HBMA's list of recommendations for how health plans can help to prevent this problem:

1. **Healthcare facilities can do more to inform patients about OON care in advance of an anticipated medical service being provided.** Recognizing true emergency situations as an exception, more can be done to have facilities inform patients about OON care they might receive.
2. **Require health plans to maintain accurate and accessible provider networks.** Health plans often do not update their provider networks in real time. Patients therefore might receive care from what their plan's directory displays as an in-network provider despite that information being outdated. In fact, some health plans do not list hospital-based providers in their directories at all. Health plans should be required to list *all* in-network providers in their directories, including hospital-based providers, in a format that is accessible to both patients and providers. Health plans should be required to update their plan directories at least every month.
3. **A change in a beneficiary's health plan network should constitute a "life event" for purposes of the individual exchange.** Patients who find that their doctor, hospital or other local provider is no longer "in-network" should have 30 days to terminate their enrollment from that plan and select another health plan. It is common knowledge that health plans will over populate their networks during the open enrollment period in order to attract enrollees and then drop many of those providers after the open enrollment period has closed. This effectively locks these patients into a plan despite the fact that their preferred hospital or physician is no longer in-network. Consumers should have

some recourse when they are the victims of this type of bait and switch action by the health plan.

4. **Improve network adequacy standards.** Policy makers should consider why providers are out-of-network in the first place. Restrictive, narrow networks that often reimburse providers at below market rates compared to commercial plans are a main reason why providers are not in-network in the first place. Congress must improve network adequacy requirements and ensure that the agencies responsible for enforcing these requirements do so effectively.
5. **Congress should require health plans to respond to requests from providers seeking to join their network within 45 days of receipt of that request.** This response should be more meaningful than an acknowledgement that the request was received. The response should include a definitive response regarding the health plan's interest in including the practice in their network.
6. **Congress should factor the credentialing process into its definition of OON billing scenarios.** Often times, after a health plan agrees to include a provider in their network, the provider will have to wait months for the credentialing process to complete during which time they are technically providing OON care. Medicare contractors typically complete the credentialing process within 60-90 days. We believe commercial health plans should be held to a similar, or higher standard. Congress should treat situations where care is technically provided as OON because of the health plan's delayed credentialing process as an in-network service.
7. **Health plans should display the type of plan (ERISA, Exchange, Commercial, etc.) on the health insurance card and the electronic eligibility file.** Various state laws and federal proposals regarding unexpected OON scenarios apply differently across different types of health plans. Providers need to know what type of plan the patient has to know how the law applies in each situation.

About the Healthcare Business Management Association (HBMA)

HBMA is a non-profit, member-led trade association of companies that support doctors and other medical providers by handling their medical billing and revenue collection processes, services known as revenue cycle management (RCM). HBMA works with legislative stakeholders and federal agencies in Washington, D.C. to improve the business of medical billing and the practice of healthcare. Since its inception in 1993, HBMA and its members have encouraged professional development and adherence to the HBMA Code of Ethics, advocated on behalf of the RCM profession, and promoted business development through educational events, networking opportunities, certification programs, and a wide range of affiliated vendor resources. For more information about HBMA, visit the www.hbma.org.