2003 REPORT OF THE
JOINT COMMISSION ON HEALTH CARE

REVIEW OF REIMBURSEMENT OF NONCONTRACTING ANCILLARY SERVICES PROVIDERS

(SJR 125)

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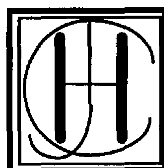

Preface

Senate Joint Resolution 125 would have established a 14-member joint subcommittee to examine issues related to reimbursement of noncontracting ancillary services providers. The Senate Committee on Rules forwarded SJR 125 to the Joint Commission on Health Care (JCHC) for study.

SJR 125 cited "situations whereby a consumer receives services, primarily surgery, within a participating hospital from a participating physician and assumes that all services in this setting will be provided by participating providers. Frequently, although health carriers notify consumers that coverage may be limited in situations requiring specialty care or hospital services, consumers are surprised and chagrined to receive unexpectedly large bills from noncontracting ancillary services providers."

These types of situations most often occur when the consumer has a managed care insurance plan. In 2002, 93% of employer-sponsored health insurance coverage was provided through a managed care plan. Managed care plans typically seek to control the cost of coverage by establishing provider networks, negotiating provider reimbursement, and preauthorizing some procedures.

Health care providers are not always satisfied with the terms of the contracts offered, and sometimes decline to contract with some health insurance plans. Hospitals and other medical facilities often contract separately with health care providers, particularly providers of such ancillary services as anesthesiology, radiology, and pathology.

The Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection reported that 2 of 63 complaints received from January – June 2002 addressed the issue of reimbursement of noncontracting providers.

The State Corporation Commission's Office of the Managed Care Ombudsman indicated that less than 1% of all insurance-related complaints typically address this issue. The Bureau of Insurance surveyed other states regarding the issue of balance billing by noncontracting providers. Of the 32 states that responded to the Bureau of Insurance survey:

- 29 states had received complaints
  - 13 states did not provide estimate of the percentage of complaints that balance billing represented
  - 9 states estimated < 1% of total
  - 1 state estimated > 1% of total
  - 6 states estimated between 4% and 10-15%.

- 7 states have statutes or regulations to address reimbursement of noncontracting providers.

- All 7 states protect the consumer from having to pay noncontracting providers more than what they would have to pay a contracting provider (usually a co-pay)
  - Colorado, Florida, Maine and North Carolina do not specify payment amount but it appears to be billed charges
  - Maryland specifies that trauma physicians be paid 140% and other physicians be paid 125% of Medicare rate
  - Utah requires the same reimbursement as contracting providers under a non-capitated arrangement
  - West Virginia requires "normal charges" be reimbursed; how "normal charges" are determined is a source of controversy.

Some approaches such as providing better consumer notification would fail to ensure that an enrollee would never have to pay directly for the services of a noncontracting provider; to reach that goal would require significant marketplace interventions.

A group of interested parties was convened by the Virginia Association of Health Plans. The following statement was sent to JCHC staff regarding the consensus reached by the group:

> "In discussions this summer…there was consensus that this issue does not lend itself well to a legislative solution. The groups agreed to continue to work cooperatively and with respective members to better facilitate communication with patients/enrollees."

A number of policy options were offered by JCHC regarding reimbursement of noncontracting ancillary providers for public comment. The policy options are shown on pages 25 and 26. A summary of the public comments received is included in Appendix B.

Action Taken by JCHC

JCHC voted to accept Option 1, to take no action.

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I.
Authority for the Study/Organization of Report

Senate Joint Resolution 125 of the 2002 General Assembly Session would have established a 14-member joint subcommittee to examine issues related to reimbursement of noncontracting ancillary services providers. The summary of SJR 125 reads:

> This resolution describes situations whereby a consumer receives services, primarily surgery, within a participating hospital from a participating physician and assumes that all services in this setting will be provided by participating providers. Frequently, although health carriers notify consumers that coverage may be limited in situations requiring specialty care or hospital services, consumers are surprised and chagrined to receive unexpectedly large bills from noncontracting providers. In conducting its study, the joint subcommittee must (i) examine the circumstances that result in the provision of services in participating facilities by noncontracting providers; (ii) determine the pervasiveness of these circumstances within the Commonwealth; (iii) research other states' laws regarding the issues; and (iv) evaluate potential solutions. In pursuing these directives, the joint subcommittee will seek input from consumers, employers, physicians, including hospital-based physicians, hospitals and health systems, health maintenance organizations, other managed care organizations, and health insurance companies, insurance brokers, medical and other health care associations, and the Office of The Managed Care Ombudsman within the Bureau of Insurance.

The Senate Committee on Rules forwarded SJR 125 to the Joint Commission on Health Care (JCHC) for study. A copy of the transmittal letter to JCHC and a copy of SJR 125 as introduced are included in Appendix A.

Organization of Report

This report is presented in four major sections. This section discussed the authority for this study of noncontracting ancillary services providers. Section II provides an overview of the issues surrounding health care reimbursement and noncontracting ancillary services providers. Section III will address considerations in placing additional requirements on consumers, health insurance plans, ancillary services providers, and hospitals to address payment issues. Section IV provides a

series of policy options the Joint Commission on Health Care may wish to consider in addressing the issues raised in this study.

II.
Background

Health Care in America Has Undergone Significant Change in the Last 15 Years Moving from a Fee-for Service System to a Predominantly Managed Care System

In 1988, 71 percent of Americans with health care coverage participated in a traditional fee-for-service health plan while only 29 percent (approximately 60 million Americans) participated in a managed care plan. In 2002, 93 percent of employer-sponsored health insurance coverage is provided through a managed-care plan.

The State Corporation Commission (SCC) described the continuum of "managed care" in its review of health maintenance organizations (HD 11 – 1998) in the following manner:

> In its simplest form, managed care includes such basic mechanisms as pre-certification of hospital stays or utilization review to ensure that services received by patients are medically necessary. Such "managed care" processes exist in many different types of health insurance, including indemnity plans. More advanced forms of managed care, such as those often referred to as preferred provider organizations (PPOs) and point of service (POS) plans, not only require utilization review and medical necessity determinations, but also provide incentives for enrollees to receive care from selected network providers in order to obtain the highest level of the plan's benefits. Some PPOs and most POS plans also require an enrollee to select and use a primary care physician (PCP) who provides primary care and coordinates access to other health care services. The highest form of managed care is provided by HMOs [health maintenance organizations] which are the only entities that must provide statutorily defined "basic health care services." Most HMOs require enrollees to select a PCP, require use of network physicians, unless a POS option is included; and generally have more limited networks of specialty providers than PPOs and POS plans.

The situations that SJR 125 seeks to address generally relate to the higher end of management of care in which a noncontracting provider receives partial or no reimbursement for the care provided and the consumer receives a bill for some or all of the provider's charge. In order to understand the billing situation faced by the consumer, a general description of health care reimbursement will be examined.

Health Insurance Plans. Health insurance plans, particularly managed care plans often seek to control the cost of their health insurance coverage in a number of ways. One of the principal ways is by establishing provider networks in which health care practitioners and hospitals agree to accept a certain payment level in exchange for the volume of patients the health insurance plan can provide. Patients may also be required to seek approval (or preauthorization) before seeing a specialist or having a procedure completed. Virginia, like other states, has statutorily required a number of patient protections including requiring health plans to allow certain specialists to be seen without referral and to reimburse for certain tests and procedures.

Health Care Providers. The term health care provider is being used broadly to include physicians, physical therapists, and other health care professionals. Health care providers are not always satisfied with the terms of the contracts offered by health insurance plans. In recent years, a number of providers have taken action to address their dissatisfaction with managed care. "The Changing Face of Managed Care" in the January/February 2002 *Health Affairs* describes this reaction as "pushback." Health care providers were surveyed and many indicated that "pushback" was in response to dissatisfaction with "low payment rates and loss of autonomy[,]...failure to pay claims promptly and...seemingly arbitrary service authorization denials...." Some providers have formed partnerships which enhance their bargaining power in deciding whether to contract with health insurance plans.

Authority of Hospitals and Other Medical Facilities. Hospitals and other medical facilities such as ambulatory surgery centers often contract with health care providers, particularly providers of such ancillary services as anesthesiology, radiology, and pathology. In these instances, the providers are not facility staff which means the medical facility has limited authority over them. In some cases, the contract providers or provider partnerships choose not to contract with the health insurance plans accepted by the medical facility. This means that these ancillary service providers have not agreed to accept the insurance rates or payments.

Consumer Situation. The consumer often fails to understand the contractual underpinnings of the hospital or medical facility. As stated in SJR 125, "many consumers assume that, if they have chosen participating physicians and participating hospitals and have properly obtained preauthorization for surgery or other services, the costs of the ancillary

services delivered in a hospital will be covered...." This is not always the case, however. Consumers often do not realize that they may receive a sizeable bill from a provider who works within a hospital or medical facility but does not contract with the consumer's health insurer. The practice of billing the consumer for charges that are greater than the amount reimbursed by the health insurance plan is known as "balance billing."

Consumer Complaints. JCHC staff contacted representatives of the Center for Quality Health Care Services and Consumer Protection within the Virginia Department of Health and the Office of the Managed Care Ombudsman within the SCC regarding consumer complaints the units have received. Staff within both units assist consumers in understanding and resolving problems with their managed care plans.

Staff of the Center for Quality Health Care Services reviewed the managed care-related complaints received during the six-month period of January through June 2002. Of the 63 complaints received, two addressed the issue of being billed for services provided by nonparticipating ancillary service providers. One complaint is under review and the other resulted in the health insurance plan reimbursing for the services.

The Office of the Managed Care Ombudsman did not provide specific numbers but indicated that less than one percent of complaints received addressed the issue of reimbursement of noncontracting ancillary services providers. The *Report of the State Corporation Commission on the Activities of the Office of the Managed Care Ombudsman* in 2001 addressed MCHIP complaint data, in stating:

> The Office...worked with the Virginia Department of Health's Center for Quality Health Care Services and Consumer Protection (the Center) to receive and collect the annual complaint report required from each MCHIP....[T]his analysis did not suggest any significant problems with any specific MCHIP, another analysis was performed. This analysis produced a complaint ratio, which compared the number of complaints to the number of enrollees in each MCHIP. This analysis did not produce any meaningful result because the number of enrollees filing formal complaints with any MCHIP yielded an extremely low ratio, typically .01% or less. This does not, however, diminish the importance of the claims of those MCHIP enrollees whose complaint involved a very serious issue. It does appear to substantiate consumer surveys conducted by the managed care industry in which an overwhelming percentage of consumers are satisfied with their managed care plan.

In summary, neither the Center for Quality Health Care Services nor the Office of the Managed Care Ombudsman currently receives a large number of complaints about managed care. Moreover, of the complaints that are received, less than one percent addresses problems involving payment of noncontracting ancillary services providers.

The Bureau of Insurance Surveyed Other States on Behalf of JCHC Regarding the Issue of Balance Billing by Noncontracting Providers

Thirty-two states responded to the Bureau of Insurance (BOI) survey which included the following questions:

1. Has your state received complaints regarding balance billing by noncontracting ancillary services providers? Yes___ No___

   If yes, approximately what percent of the total number of complaints that you receive are related to noncontracting ancillary services providers?

   _____ percent

2. Does your state have any statutes or regulations that address issues surrounding noncontracting ancillary services providers?

   If yes, please provide the statutory cite and either attach the code section to this email or fax a copy.

The survey responses are summarized in Figure 1.

While 29 of the 32 states reported that complaints have been received regarding balance billing, a variety of opinions were reported regarding the seriousness of the problem within their states. As indicated in Figure 1, 13 states were unable to estimate the percentage of the total number of complaints that noncontracting provider complaints represent. In qualifying the answer that no estimate could be given, four states indicated that there were few such complaints, one state indicated that the number represents a significant problem, and one state indicated the number of complaints is increasing. Of the remaining responses: 9 states indicated that noncontracting provider complaints make up less than 1 percent of complaints, one state indicated the complaints represent more than 1 percent of the total and it is a significant number, and six states provided estimates of 4 to as high as 10 to 15 percent.

Figure 1
Summary of States Reporting on Complaints of Balance Billing by Noncontracting Ancillary Services Providers

States Reporting Complaints	Percentage of Total Complaints	Applicable State Statutes or Regulations
Arizona	No estimate	
California	<1%	
Colorado	No estimate	***Colorado Revised Statutes*** **§ 10-16-704**
Florida	<1%	***Florida Code*** **§ 641.315.(1)**
Georgia	No estimate-very few	
Hawaii	9%	
Idaho	No estimate but a significant problem	None, but health plans are expected to have a sufficient number of providers
Iowa	No estimate-very few	
Illinois	<1%	
Indiana	0.5%	
Kentucky	<1%	
Louisiana	No estimate-very few	
Maine	<1%	**Maine BOI Rule 850**
Maryland	No estimate	***Code of MD*** **§ 19-710 et. seq.**
Michigan	No estimate	
Mississippi	<1%	
Nebraska	<1%	
Nevada	8%	
New Jersey	No estimate-but rising	No but regulation being drafted
North Carolina	<1%	**NC General Statute § 58-3-200.(d)**
Oklahoma	5-10%	
Pennsylvania	No estimate	
South Carolina	10-15%	
South Dakota	No estimate-not major	
Tennessee	No estimate	
Texas	10%	
Utah	No estimate	***Utah Code*** **§ 31A-8-501**
Wisconsin	4%	
West Virginia	>1%-a significant number	***West VA Code*** **§ 33-25A-7**

States Reporting No Complaints

Alabama
Arkansas
Rhode Island

Source: State Corporation Commission Bureau of Insurance Survey of Other States, August 2002.

Seven of the 32 responding states indicated they have statutes or regulations that address noncontracting ancillary services providers. Six states (Colorado, Florida, Maryland, North Carolina, Utah, and West Virginia) address the issue through state statute while Maine addresses it through insurance regulation. The provisions included in state statutes and regulations are described in greater detail in the following report sections. In general, however, the statutory/regulatory provisions in all but one state (Utah) specifically protect consumers from having to pay nonparticipating providers more than they would have paid a provider who participates in their health insurance plan. In each of the seven states, requirements are placed on health insurance plans to reimburse nonparticipating providers under specified circumstances.

Colorado Provides Consumer Protections Through Statute. Colorado statutorily protects health insurance plan enrollees from extraordinary health care bills from nonparticipating providers. *Colorado Revised Statutes* § 10-16-704 reads in part:

> (2) In any case where the carrier has no participating providers to provide a covered benefit, the carrier shall arrange for a referral to a provider with the necessary expertise and ensure that the covered person obtains the covered benefit at no greater cost to the covered person that if the benefit were obtained from participating providers.
>
> (3) When a covered person receives services or treatment in accordance with plan provisions at a network facility, the benefit level for all covered services and treatment received through the facility shall be the in-network benefit.

It was noted on the Colorado survey that the statute had resulted in unintended consequences, providing "a major disincentive for providers to contract with carriers knowing that they could get billed charges through enforcement of this consumer protection."

Florida Provides Consumer Protections Through Statute. Florida specifically protects enrollees of <u>HMOs</u> from extraordinary bills from nonparticipating providers. *Florida Code* § 641.3154 requires HMOs to reimburse providers for rendering covered services to HMO enrollees regardless of whether the providers contract with the HMOs or not. The Florida statute also indicates that HMO enrollees are not liable for any of the billed fees. Health services providers, whether they are participating providers or not, are statutorily prevented from "collect[ing] or attempt[ing] to collect money from, maintain any action at law against, or

report to a credit agency" any enrollees whose HMOs are liable for charges. The Florida statute that was provided did not specifically address how the payment amount due to the noncontracting provider should be determined.

Maine Provides Consumer Protections Through Bureau of Insurance Regulations. Maine's Bureau of Insurance Chapter 85: Health Plan Accountability, Section 7, Subsection B reads in part:

> 3) Carriers that offer managed care plans shall contract with or employ sufficient numbers of appropriately licensed providers of ancillary services....
>
> 5) In any case where the carrier has an insufficient number or type of participating provider to provide a covered benefit, the health carrier shall ensure that the covered person obtains the covered benefit at no greater cost to the covered person than if the benefit were obtained from participating providers, or shall make other arrangements acceptable to the Superintendent [of Insurance].

Thus in Maine, managed care plans are expected to contract with a sufficient number of ancillary services providers. If that is not the case, however, the managed care plan is required to ensure that there is no cost to the plan's enrollee in excess of what receiving the service from a participating provider would have cost.

Maine also addresses the issue of sufficiency within Section 85 based on four pages of criteria (and description) addressing access to basic care (such as one full-time primary care provider for 2000 enrollees), geographic access, timely access, and access to emergency and urgent care.

Maryland Takes a Two-Pronged Approach to Protect the Consumer. Maryland has taken legislative steps to ensure that enrollees of HMOs will not be asked to pay for additional charges from a provider who does not contract with the enrollees' HMOs.

Title 19 of the *Code of Maryland* addresses the operation of HMOs. Section 19-710.(i)(2) is a hold harmless clause that prevents a "provider of health services" from seeking reimbursement from a "subscriber, member, enrollee, patient, or any other persons other than the health maintenance organization acting on their behalf, for services provided in accordance with the provider contract." Exclusions to this hold harmless clause are made in the subsequent subsection and include "copayments or supplemental charges in accordance with the terms of the subscriber's

contract with the health maintenance organization, or charges for services not covered under the subscriber's contract..." This hold harmless clause amounts to a prohibition against balance billing by health services providers of HMO enrollees.

The prohibition against balanced billing is coupled with language in Section 19-710.1 which addresses payments that HMOs must make to noncontracting health care providers. The statutory language requires HMOs to provide the following compensation:

> 2. A trauma physician for trauma care rendered to a trauma patient in a trauma center, at the greater of:
>
> A. 140% of the rate paid by the Medicare program, as published by the Health Care Financing Administration, for the same covered service, to a similarly licensed provider; or
>
> B. The rate as of January 1, 2001 that the health maintenance organization paid in the same geographic area, for the same covered service, to a similarly licensed provider; and
>
> 3. Any other health care provider at the greater of:
>
> A. 125% of the rate the health maintenance organization pays in the same geographic area, for the same covered service, to a similarly licensed provider under written contract with the health maintenance organization; or
>
> B. The rate as of January 1, 2000 that the health maintenance organization paid in the same geographic area, for the same covered service, to a similarly licensed provider not under written contract with the health maintenance organization.

Thus, while health services providers are not allowed to balance bill, they are guaranteed a reimbursement rate that is defined in statute.

North Carolina Statutorily Provides Consumer Protections. A bulletin circulated by the North Carolina Department of Insurance in June 2002, provided the following interpretation of *North Carolina General Statute* § 58-3-200.(d):

> Network plans may restrict or limit coverage for health care services obtained from non-participating providers and may include provisions in their insurance contracts prohibiting the assignment of benefits to non-participating providers.
>
> Under North Carolina General Statute § 58-3-200.(d), insurers are prohibited from penalizing or subjecting insureds to out-of-network benefit levels when an insured receives covered services from a non-participating provider because a participating provider was not reasonably available without unreasonable

> delay....Therefore, insurers are required to take steps to prevent insureds from being in the position of having to make payment at the time of service (other than applicable deductibles, copayment or coinsurance) and awaiting reimbursement, in cases where services are rendered by non-network providers because a network provider is not reasonably available without unreasonable delay.

This Bulletin clarifies that managed care plans are not required to reimburse nonparticipating providers when there are a sufficient number of network providers. However, if it is determined that a plan enrollee received services because a participating provider was "not reasonably available without unreasonable delay" the managed care plan will be required to reimburse the nonparticipating provider. The Bulletin did not explain how reasonable availability would be determined.

Utah Statutes Requires HMOs to Reimburse Noncontracting Providers. *The Utah Code* § 31A-8-501.(4)(a) requires health maintenance organizations to provide noncontracting providers the same reimbursement that would be provided for "contracting providers under a noncapitated arrangement for comparable services." HMOs are not required to pay for services resulting from a referral by a noncontracting provider to another noncontracting provider unless specific conditions are met. These conditions include authorization for the referral from the HMO; or that the "practice location of the noncontracting provider to whom the referral is made: (i) is located in a county with a population density of less than 25 people per square mile; and (ii) is within 30 paved road miles" of the enrollee's home."

The Utah statute sent to the Bureau of Insurance does not specifically protect consumers from being billed by noncontracting providers for any charges that are above the reimbursement amounts they receive.

West Virginia Statutes Provide Broad Protection Against Balance Billing. The survey received from West Virginia explained the *West Virginia Code* § 33-25A-7 as providing broad protection for consumers against balance billing by health services providers regardless of whether the provider contracts with a managed care plan or not. A patient may only be billed when the "patient knowingly goes out of network for services, without a referral by the patient's primary care provider, and the HMO will not cover the services."

West Virginia's statutory provisions also require nonparticipating providers to be paid for "normal" charges by the HMO. Since West Virginia's statutes and insurance regulations fail to define what constitutes "normal" charges, that matter is currently a source of controversy.

New Jersey Is in the Process of Drafting a Regulation to Provide Consumer Protections. New Jersey does not have statutes or regulations in place at this time to address the issue on nonparticipating providers. Regulations are being drafted for consideration that "would provide that if a covered person is admitted to a network hospital by a network physician, then all services rendered during the admission would be treated as network services." The survey submitted by New Jersey noted that while the number of complaints they had received regarding balance billing could not be estimated, the number is rising particularly related to services provided by anesthesiologists.

III.
Addressing the Reimbursement of Noncontracting Ancillary Services Providers

The issues surrounding the reimbursement of noncontracting ancillary services providers can be approached in a number of different ways. Some approaches, such as providing better notification to consumers of the potential problem, would not ensure that a health insurance enrollee would never have to pay directly for the services of a noncontracting ancillary services provider. To reach that goal would require significant marketplace interventions.

A group of interested parties was convened by the Virginia Association of Health Plans following the introduction of SJR 125. The following statement was sent to JCHC staff regarding the consensus reached by the group: "In discussions this summer among representatives of the Medical Society of Virginia, Virginia Association of Health Plans, Virginia Hospital & Healthcare Association, and Virginia Society of Anesthesiologists, there was consensus that this issue does not lend itself well to a legislative solution. The groups agreed to continue to work cooperatively and with their respective members to better facilitate communication with patients/enrollees. "

The following sections discuss possible ways to address the current problem and some of the potential consequences of each proposal. The proposals are not exhaustive and could be used in combination with each other.

Proposals that Focus on Enrollees to Address Payment Issues Related to Noncontracting Ancillary Services Providers

Figure 2 presents the current situation in which the health insurance enrollee is expected to understand his/her coverage and be responsible for any expenses that are in addition to the insurance reimbursement. As noted, placing the responsibility solely on the enrollee will not ensure that the enrollee will be able to always avoid ancillary services charges that are not covered by health insurance.

Figure 2
Considerations Related to Placing Requirements on the Enrollees

Possible Actions	Potential Consequences
Require enrollees to understand and adhere to the provisions of their health insurance plans and be responsible for ensuring that all of the ancillary services providers used participate with their health insurance plans.	Enrollees who do not understand the provisions of their health insurance plans may receive unexpected bills from ancillary providers. Enrollees may not be able to avoid ancillary services charges that are not covered by their insurance plans when (i) services are provided in emergency situations or (ii) no ancillary services providers within the medical facility or geographic area participate in the enrollees' health insurance plans.

Proposals that Focus on Health Insurance Plans to Address Payment Issues Related to Noncontracting Ancillary Services Providers

Figure 3 shows some actions that could be required of health insurance plans. Currently, health insurance plans are required to explain the general provisions and limitations of their plans in an evidence of coverage (EOC) or some type of equivalent benefit statement. Enrollees may not carefully read these benefit statements and when they do, the statements are not always easy to understand. Managed care plans typically address the reimbursement provided for nonparticipating or "out-of-network" providers and the fact that reimbursement may be decreased or disallowed completely if the enrollee chooses to use the services of one of these providers. The benefit statements generally do not make it clear that these nonparticipating providers may include ancillary providers who work within the hospitals or other medical facilities that contract with the health insurance plans.

Figure 3
Considerations Related to Placing
Additional Requirements on Health Insurance Plans

Possible Actions	Potential Consequences
Provide more effective notification of the potential to receive services from a noncontracting provider within a participating medical facility.	Increased cost to the health insurance plan (the amount of the increase would depend on the form of notification requirements.)
Require existing health insurance plans to contract with at least one provider of each type of ancillary service (that may separately bill an enrollee) in every medical facility that participates in the plan.	Increased administrative burden. Decreased bargaining power which might result in having to offer higher reimbursement rates to secure contracts. Decreased availability of health insurance plans resulting in decreased consumer choice and access and higher costs to enrollees and employers.
Require new or expanding health insurance plans to contract with at least one provider of each type of ancillary services available in each medical facility that participates in the plan.	Increased administrative burden. Decreased bargaining power which might result in having to offer higher reimbursement rates to secure contracts. Decreased availability of health insurance plans resulting in decreased consumer choice and access and higher costs to enrollees and employers.
Require health insurance plans to pay for ancillary services regardless of whether the provider participates with the plan or not. This reimbursement level could range from the payment the plan would provide a participating provider to the provider's actual charge.	Decreased bargaining power to encourage providers to participate in health insurance plans which could result in higher provider reimbursement rates. Decreased availability of health insurance plans resulting in decreased consumer choice and access and higher costs to enrollees and employers. No assurance that ancillary services providers would refrain from billing enrollees for unpaid charges except in the instances in which the health insurance plans reimburse actual charges.

Language from the Key Advantage Handbook. Key Advantage is the statewide employee health insurance plan in which more than 80 percent

of state employees enrolled for FY 2003. An extract from the Key Advantage Member Handbook is shown in Figure 4 as an example of the type of language that is often included in health insurance plan explanations.

Figure 4
Extract of Language from the Key Advantage Member Handbook

9) Out-of-Network Payments
When a Participant receives services from a Non-Network Provider, the Company may choose to make payment directly to the Enrollee or, at the Company's sole option, to any other person responsible for payment of the Provider's charge. Payment will be made only after the Company has received an itemized bill and the medical information the Company decides is necessary to process the claim. The Company will reduce by 25% the amount the Plan would have paid to a Network Provider for the same service. Payment will be made directly to the Enrollee. The Enrollee will also be responsible for the difference between the Plan's allowance and the Provider's charge. Payment by the Company will relieve it and the Plan of any further liability for the Non-Network Provider's services.

MAJOR MEDICAL SERVICES
Services Which Are Eligible for Reimbursement
2) Customary ancillary services for Inpatient stays, including operating rooms, medications, oxygen and oxygen tents, dressings and casts, anesthesia, transfusions, blood, blood plasma, blood derivatives, blood volume expanders, and professional donor fees, Diagnostic and Therapy Services, emergency room services leading directly to admission or to death, ambulance services for transportation between local Hospitals when Medically Necessary, and routine nursery care of a newborn as part of a mother's covered maternity service.

Source: Key Advantage Member Handbook, July 2001.

As shown in Figure 4, the Key Advantage Handbook discusses the issue of out-of-network payments without addressing the possibility that some of the services provided within a hospital or other medical facility may actually be considered to be out-of-network payments. Key Advantage's reimbursement policy is to pay the out-of-network provider 75 percent of what a network provider would be paid. As noted in the Handbook, the enrollee should expect to be responsible for the remaining difference between the reimbursement provided by Key Advantage and the service provider's charge.

The explanation given within the Key Advantage handbook under "Major Medical Services" fails to alert the enrollee that some inpatient services may not be covered. As noted in Figure 4, a wide variety of ancillary services are listed as being "eligible for reimbursement" with no explanation that some of the inpatient ancillary services may be provided by out-of-network providers and therefore reimbursed at 75 percent of the rate paid to participating providers.

EOCs often include language that indicates the enrollee's primary care physician (PCP), in requesting the preauthorization for hospital admission, will coordinate the services provided. This may give the enrollee the impression that all of the care provided in a hospital will be covered since it is being coordinated by the PCP and approved by the health insurance plan.

The 2001 *Report of the State Corporation Commission on the Activities of the Office of the Managed Care Ombudsman* reiterates the point that consumers often do not understand their coverage. The *Report* states: "Based upon assisting consumers with inquiries and appeals, the Office has determined that the most common reasons consumers experience problems with their MCHIP is that consumers do not understand how their health insurance works, and they are unaware of the terms and conditions of their health care coverage. This essential information is presented in the Evidence of Coverage or equivalent document the each MCHIP is required to provide to each insured individual."

Improved Notification of Health Insurance Enrollees. Improved notification could take a number of different forms. Health insurance plans could add language to their EOCs and within their member handbooks to explain that ancillary services within a hospital or medical facility may be provided by a noncontracting services provider resulting in costs that the enrollee would be responsible for paying. Flashing notices on insurance plan websites would be another way to alert plan enrollees of the possible situation. An additional means of notification would be for the insurance plan to send a letter or include language within its preauthorization approval notice that explains the possible consequences related to ancillary services being provided by noncontracting providers. Clearly this type of notification would only be effective for non-emergency procedures requiring preauthorization.

It should be noted that notification efforts would have some cost to the health insurance provider – in terms of the notification itself and in the increased customer assistance calls that would result.

Requirement for Health Insurance Plans to Either Contract with Ancillary Services Providers or Reimburse the Providers. The requirements shown in Figure 3 for health insurance plans to contract with or reimburse ancillary providers would decrease the bargaining power of the plans. A representative of a large insurance company in Virginia talked with JCHC staff and questioned the advisability of the requirements. The representative indicated that health insurance plans are already in a disadvantaged position in seeking to contract with hospital-based providers. The providers already have contracts with the hospital and are therefore "guaranteed" to be able to provide the needed services.

As noted previously, seven of the 32 states that responded to the Bureau of Insurance survey, require health insurance plans to reimburse noncontracting providers under specified circumstances. Four of the states (Colorado, Florida, Maine, and North Carolina) do not specify the amount of reimbursement to be provided but indicate that the enrollee must not have to pay more than would be required to see a participating provider. Colorado's survey indicated that requirement had resulted in the unintended consequences of providers have no incentive to health insurance plans since their billed charges would be paid. It should also be noted that requiring reimbursement from health insurance plans without prohibiting ancillary services providers from balance billing provides only partial protection for enrollees – enrollees would be protected from paying the entire charge but could still be billed from the amount that exceeded the health insurance plan's reimbursement.

The Majority of Health Insurance Plans Seem to Provide Some Level of Reimbursement for Hospital-Based Ancillary Services Providers Who Do Not Contract with the Plans. The Virginia Association of Health Plans surveyed its membership regarding how they handle reimbursement of hospital-based noncontracting providers. All of the plans that responded to the VAHP survey indicated that they provide some level of reimbursement. The basis for the reimbursement varied among the plans and included the rate allowed for out-of-network providers, the rate considered to be "reasonable and customary," and the actual charges billed by the service provider.

Senate Bill 816 (2001) Would Have Required Health Insurance Plans to Reimburse Noncontracting Ancillary Services Providers Unless the Plans' Enrollees Provided Written Acknowledgements. SB 816 represents an alternative way of requiring health insurance plans to pay for ancillary services regardless of whether the provider participates with the plan or not. SB 816 would have amended *Code of Virginia* § 38.2-3407.17 to state:

> "[that no health insurance plan] licensed in the Commonwealth shall deny coverage for an ancillary service provided by a nonparticipating ancillary service provider, or pay or reimburse a nonparticipating ancillary service provider less than it would be obligated to pay a participating provider for such medical service, unless the accident and sickness insurer, health maintenance organization, or health services plan has obtained from the covered person a written acknowledgement that (i) ancillary services rendered by a nonparticipating ancillary service provider may not be fully covered by the covered person's health care plan and (ii) the covered person shall be responsible to a nonparticipating ancillary service provider for the difference between the amount that is billed by the nonparticipating ancillary service provider for the ancillary services and the amount that the accident and sickness insurer, health maintenance organization, or health services plan pays or reimburses for such medical services."

In addition, SB 816 would have defined "ancillary service" as "a medical service, including but not limited to anesthesiology and radiology services, provided to a covered person at a participating hospital or outpatient treatment facility as an element of a pre-approved medical service." Currently, ancillary services are not defined in statute.

SB 816 required health insurance plans to reimburse noncontracting ancillary providers at least as much as the plans would pay a participating provider. SB 816 did not however, preclude the nonparticipating provider from billing the consumer for charges that were greater than the amount reimbursed by the health insurance plan.

The State Commissioner of Insurance wrote in a letter to the patron of SB 816, suggesting strengthening the language of the bill to better protect the consumer. The letter dated January 19, 2001, suggested amending the language of the bill to prohibit the health insurance plans from requiring the consumer to pay more of a copayment than would be required to be paid to a participating provider. (Consumers are frequently required to pay a higher copayment to nonparticipating providers than to participating providers.) The Insurance Commissioner's letter stated, "In our view, the...change would put a greater burden on the carrier [health insurer] to contract with ancillary service providers, without further

burdening ancillary service providers." Additional suggestions were made in the letter including:

- requiring the health insurance plan to provide the names of any ancillary services providers who participate with the plan and practice within the designated facility,
- requiring the written acknowledgement to be signed by the insurance plan's primary enrollee rather than a covered enrollee, and
- requiring the acknowledgement to be signed at least 48 hours prior to the provision of services except in emergency situations.

SB 816 was not formally amended and was stricken from the docket of the Senate Committee on Commerce and Labor at the request of the patron.

Proposals that Focus on Ancillary Services Providers to Address Payment Issues

Figure 5 shows some actions that could be required of ancillary services providers. Representatives of ancillary services providers stated that they fear that requiring providers to either contract with health insurance plans or to accept the conditions and reimbursement rates of the plans would take away any incentive for the plans to negotiate in good faith with the providers. There is currently a delicate balance of bargaining power between the provider and the health insurance plan that allows either of the parties to choose not to enter into a contract with the other. Taking this prerogative away from either party would have significant consequences.

As noted in a number of JCHC workforces studies, there is a national and statewide shortage of many types of health services providers. These shortages are expected to worsen in the coming years (particularly with the aging of the baby boom generation). A provider shortage would seem to call into question whether placing additional requirements on providers could be implemented effectively.

Figure 5
Considerations Related to Placing
Additional Requirements on Ancillary Services Providers

Possible Actions	Potential Consequences
Require ancillary services providers (who bill enrollees separately for their services) to participate in the health insurance plans accepted by the medical facilities in which they work or to accept the reimbursement rates provided by health insurance plans as payment in full.	Decreased bargaining power for the providers which might result in lower reimbursement rates to providers. Decreased incentive to provide services within medical facilities. Reduced consumer choices. Increased costs to enrollees and employers.

Statement of the Virginia Chapter of the American College of Radiology. The Virginia Chapter of the American College of Radiology representative indicated that it is "the great desire" of hospital-based radiology groups to participate in the insurance plans of the hospitals in which they provide services. Participating in the insurance plans significantly simplifies the billing process for the radiology groups and typically benefits the radiologists' patients. The radiology groups make a "good faith effort" to participate in all of the insurance plans that their hospitals participate in and for the most part, agreement is reached particularly with the larger plans and with Medicare. However, in some instances radiology groups have difficulty negotiating fair contracts, and in those instances contractual agreements may not be reached.

With regard to workforce concerns, Virginia Chapter of the American College of Radiology representative indicated the following:

> Radiologists in Virginia also expressed workforce concerns. There is also a reported shortage of diagnostic radiologists throughout the country. According to the national organization, the American College of Radiology, imaging utilization is growing at least 5% per year, and in some communities, the growth rate is much higher. By 2010, the amount of diagnostic imaging covered by Medicare is expected to rise 140%. Yet the number of radiologists available to read those studies will grow by only 20%. The Chapter argues that requiring hospital-based physicians to accept whatever terms are offered by insurers who also contract with hospitals is not in the best interests of consumers of health care services. By sustaining free negotiation between insurers and hospital based physicians, it argues, market dynamics can drive a result that permits adequate incentives to the

physicians not to flee the hospital setting, while still restraining health care costs within reasonable bounds.

Statement of The Medical Society of Virginia. In response to discussions with JCHC staff regarding reimbursement of noncontracting ancillary services providers, The Medical Society of Virginia wrote:

> The Medical Society of Virginia believes that improved communication by physicians, hospitals and health plans with their respective patients/enrollees should be the preferred resolution to the issue addressed in this study. While we understand that the situations leading to this study arise from time to time, we are also aware that the number of non-contracting, hospital-based physicians remains relatively small. Furthermore, when these non-contracting situations do arise, they do so in a fairly fluid context, with contract negotiations most often continuing even after the effective participation date has passed and often resulting in a new or renewed contractual agreement.
>
> Requiring hospital-based physicians to participate in all hospital accepted health plans or to accept only non-participating conditions and reimbursements from plans removes a significant portion of the practitioner's leverage in negotiating an equitable rate for services provided. In addition, it would create a strong disincentive for plans to engage in good faith negotiations while developing provider networks. Although Maryland has chosen that approach, it is important to consider the context in which that occurred. Maryland has always been a more intrusive state than Virginia in the area of health care reimbursement: the presence of a Health Services Cost Review Commission that still approves hospital rates is a prominent example. We believe that mandating either contract participation or the conditions and rates of non-participation are counter productive to the relative balance achieved by the availability of the negotiation process, particularly as it relates to the development of hospital and hospital-based physician provider networks.

Proposals that Focus on Medical Facilities to Address Payment Issues

Figure 6 shows some actions that could be required of medical facilities. The focus of the facility-based actions involves applying pressure on service providers who contract with the medical facilities. It is not clear that medical facilities would be in a position to enforce a requirement for ancillary services providers to either participate in each of the health insurance plans accepted by the facility or accept the reimbursement rates provided by the health insurance plans. In addition, it should be noted that medical facilities frequently contract with a number of health insurance plans.

Figure 6
Considerations Related to Placing
Additional Requirements on Medical Facilities

Possible Actions	Potential Consequences
Require medical facilities (that employ ancillary services providers who separately bill enrollees for their services) to employ only ancillary services providers who (i) participate in all of the health insurance plans accepted by the facility or (ii) accept the reimbursement rates provided by the health insurance plans.	Increased administrative burden. Decreased bargaining power for the hospital which might result in higher reimbursement rates for providers. Decreased incentive to contract with a large number of health insurance plans. Decreased incentive and perhaps ability to provide services within hospitals. Reduced consumer choices. Increased costs to enrollees and employers.

The Virginia Hospital & Healthcare Association (VHHA) Indicates that Hospitals Prefer for Health Services Providers to Participate with the Same Insurance Plans but that Hospitals Are in No Position to Require Participation. VHHA supplied JCHC staff with the following written statement regarding the issue of payment of noncontracting ancillary services providers:

> Hospitals are sympathetic to the problem and generally ask, and in some facilities require hospital-based physicians to participate with the insurance companies with which the hospital itself contracts. The problem faced by the hospitals is that in many instances, the hospitals have no alternative to a physician group (anesthesiologists, for example) and therefore, enforcement of these provisions is untenable. In this situation, the hospital's primary concern is the availability of a qualified physician to perform a procedure, not the insurance plans that the physician accepts.
>
> Also, hospitals are leery to require or enforce these types of provisions because hospital administrators, who themselves sit through tense and lengthy negotiations with insurance companies, understand the reduced negotiating position of hospital-based physicians in their own rate negotiations with insurance plans if the physician is in fact *required* to contract with that plan. Under this scenario, the insurance company has little incentive to offer a "fair" payment rate to the physicians.

The onus is on the insurance plan and the insurance plan's member to understand what is covered and at what level. Hospitals understand that this is often not accomplished until the bill is received by the patient. Unfortunately, there is little more that a hospital can do other than encourage participation by its hospital-based physicians with the hospital's contracted plans.

IV.
Policy Options

The following Policy Options are offered for consideration by the Joint Commission on Health Care. They do not represent the entire range of actions that the Joint Commission may wish to recommend with regard to consumer protections related to noncontracting ancillary services providers.

Option I: **Take no action.**

Option II: **Introduce legislation in the form of a resolution to establish a joint subcommittee to examine issues related to reimbursement of noncontracting ancillary services providers.**

Option III: **Introduce legislation to require health insurance plans to:**

A. provide specific notification to plan enrollees that (i) a noncontracting provider may be involved in the care received within a hospital or other type of medical facility, (ii) the payment policy of the health insurance plan for services rendered by noncontracting providers, (iii) the possibility that the enrollee may receive a separate bill from the noncontracting provider for costs that the health insurance plan does not cover, and (iv) a health insurance plan contact for answering specific questions the enrollee may have about this issue;

Option III:

B. ensure that within every participating medical care facility there is a contract with at least one provider for each type of ancillary service that may result in a separate bill to an enrollee (this requirement could apply to all qualifying health insurance plans or only to qualifying plans that are new to Virginia or expanding their coverage within Virginia);

C. provide specified reimbursement to noncontracting ancillary services providers (specified reimbursement could range from the reimbursement provided for contracting providers to the noncontracting services provider's actual charge).

Option IV: Introduce legislation to require ancillary services providers that separately bill enrollees for their services to:

A. participate in all of the health insurance plans accepted by the medical facilities in which the providers work; or

B. accept the reimbursement provided by the health insurance plans as payment in full.

Option V: Introduce legislation requiring medical facilities to stipulate in contracts with ancillary services providers (who separately bill enrollees for their services) that the providers either participate in all of the health insurance plans accepted by the medical facility or accept the reimbursement rates provided by the health insurance plans.

Option VI: Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of the issue of reimbursement of noncontracting ancillary services providers.

Appendix A:

Senate Joint Resolution 125

SENATE OF VIRGINIA

BILL BOLLING
4TH SENATORIAL DISTRICT
COUNTIES OF HANOVER, CAROLINE,
ESSEX, KING AND QUEEN,
KING WILLIAM, MATHEWS,
MIDDLESEX, NEW KENT, AND RICHMOND;
PART OF GLOUCESTER COUNTY
POST OFFICE BOX 3037
MECHANICSVILLE, VIRGINIA 23116

COMMITTEE ASSIGNMENTS:
AGRICULTURE, CONSERVATION, AND NATURAL RESOURCES
EDUCATION AND HEALTH
GENERAL LAWS
PRIVILEGES AND ELECTIONS

MEMORANDUM

TO: Kim Snead
FROM: Senator Bill Bolling
DATE: February 26, 2002
RE: SJR 125

Senator Patsy Ticer introduced SJR125 for the General Assembly's consideration this year. SJR125 called for the study of issues relating to non-contracting ancillary services providers. SJR125 was considered by the Committee on Rules in the Senate, and the Committee chose to forward the legislation on to the Joint Commission on Health Care for study. Please take note of this and make certain that we include the matter on our work plan for the 2002 legislative interim.

BB/

Attachment

cc: Senator Patsy Ticer

SENATE JOINT RESOLUTION NO. 125

Offered January 11, 2002

Establishing a joint subcommittee to study issues relating to noncontracting ancillary services providers.

Patron-- Ticer

Referred to Committee on Rules

WHEREAS, accident and sickness insurers, health maintenance organizations, and health services plans provide each of their consumers with information concerning covered services and participating providers; and

WHEREAS, frequently, these health carriers notify consumers that lower reimbursement is a possibility in situations requiring specialty care, hospital services or other situations; and

WHEREAS, many consumers do read these notices; however, they may also believe that lower reimbursement levels will only occur if they do not adhere to the health carriers' stipulations concerning participating providers and preauthorization of certain services; and

WHEREAS, therefore, most consumers chose participating providers, including doctor and hospital services, in order to avoid costly balance billing charges for services; and

WHEREAS, many consumers are also aware that they must follow their health carriers' procedures to obtain preauthorization for surgery and other designated services in order to avoid unexpected costs; and

WHEREAS, however, many consumers assume that, if they have chosen participating physicians and participating hospitals and have properly obtained preauthorization for surgery or other services, the costs of the ancillary services delivered in the hospital will be covered; and

WHEREAS, no one would deny that certain services are essential to the delivery of quality health care, for example, anesthesiology services during surgery and other invasive procedures, and appropriate expert analyses of tissue samples or imaging by pathologists and radiologists; and

WHEREAS, consumers generally depend on their attending physician to choose the specialists who deliver anesthesiology, pathology, or radiology services, assuming that all providers will be, as their attending physician or surgeon is, a participating provider in their health benefits plan; and

WHEREAS, health carriers can encounter reluctance to contract on the part of hospital-based provider groups; and

WHEREAS, often hospitals must, because of local circumstances or other factors, arrange for such ancillary services with noncontracting providers, and the attending physician's choice will be curtailed; and

WHEREAS, thus, consumers are often surprised and chagrined to discover through an explanation of benefits (EOB) or an unexpected bill for services that some services incidental to hospital care have been delivered by a noncontracting provider, and that they are responsible for the balance of the costs; and

WHEREAS, the bill that the consumer receives can be for an unexpectedly large sum and this bill may be received at a time when the consumer is experiencing additional expenses or reduced income because of illness; and

WHEREAS, although these circumstances have resulted in a number of consumer complaints to health benefits providers, the Bureau of Insurance, and to elected officials, remedies for these problems have not yet been devised; now, therefore, be it

RESOLVED by the Senate, the House of Delegates concurring, That a joint subcommittee be established to study issues relating to noncontracting ancillary services providers. The joint subcommittee shall be composed of 14 members, which shall include 12 legislative members and two ex officio members as follows: seven members of the Senate, to be appointed by the Senate Committee on Privileges and Elections; five members of the House of Delegates, to be appointed by the Speaker of the House, in accordance with the principles of proportional representation contained in the Rules of the House of Delegates; and the Secretary of Health and Human Resources and the Commissioner of Insurance or their designees to serve ex officio with full voting privileges.

In conducting its study, the joint subcommittee shall (i) examine the circumstances that result in the provision of services in participating facilities by noncontracting providers; (ii) determine the pervasiveness of these circumstances within the Commonwealth; (iii) research other states' law regarding the issues; and (iv) evaluate potential solutions. In pursuing these directives, the joint subcommittee shall seek input from consumers, employers, physicians, including hospital-based physicians, hospitals and health systems, health maintenance organizations, other managed care organizations, and health insurance companies, insurance brokers, medical and other health care associations, and the Office of The Managed Care Ombudsman within the Bureau of Insurance.

The direct costs of this study shall not exceed $12,000.

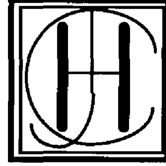
The Division of Legislative Services shall provide staff support for the study. All agencies of the Commonwealth shall provide assistance to the joint subcommittee, upon request.

The joint subcommittee shall complete its work by November 30, 2002, and shall submit its written findings and recommendations to the Governor and the 2003 Session of the General Assembly as provided in the procedures of the Division of Legislative Automated Systems for the processing of legislative documents.

Implementation of this resolution is subject to subsequent approval and certification by the Joint Rules Committee. The Committee may withhold expenditures or delay the period for the conduct of the study.

Appendix B:

Summary of Public Comments



JOINT COMMISSION ON HEALTH CARE

SUMMARY OF PUBLIC COMMENTS:

Reimbursement of Noncontracting Ancillary Services Providers (SJR 125)

Organizations/Individuals Submitting Comments

Four individuals/organizations submitted comments in response to the reimbursement of noncontracting ancillary services providers study:

- Medical Society of Virginia
- Virginia Association of Health Plans
- Virginia Chapter American College of Radiology
- Virginia Hospital & Healthcare Association

Policy Options Included in the Issue Brief Evaluating the Reimbursement of Noncontracting Ancillary Services Providers

Option I: **Take no action.**

Option II: **Introduce legislation in the form of a resolution to establish a joint subcommittee to examine issues related to reimbursement of noncontracting ancillary services providers.**

Option III: Introduce legislation to require health insurance plans to:

A. provide specific notification to plan enrollees that (i) a noncontracting provider may be involved in the care received within a hospital or other type of medical facility, (ii) the payment policy of the health insurance plan for services rendered by noncontracting providers, (iii) the possibility that the enrollee may receive a separate bill from the noncontracting provider for costs that the health insurance plan does not cover, and (iv) a health insurance plan contact for answering specific questions the enrollee may have about this issue;

Option III: B. ensure that within every participating medical care facility there is a contract with at least one provider for each type of ancillary service that may result in a separate bill to an enrollee (this requirement could apply to all qualifying health insurance plans or only to qualifying plans that are new to Virginia or expanding their coverage within Virginia);

C. provide specified reimbursement to noncontracting ancillary services providers (specified reimbursement could range from the reimbursement provided for contracting providers to the noncontracting services provider's actual charge).

Option IV: Introduce legislation to require ancillary services providers that separately bill enrollees for their services to:

A. participate in all of the health insurance plans accepted by the medical facilities in which the providers work;

B. accept the reimbursement provided by the health insurance plans as payment in full.

Option V:	**Introduce legislation requiring medical facilities to stipulate in contracts with ancillary services providers (who separately bill enrollees for their services) that the providers either participate in all of the health insurance plans accepted by the medical facility or accept the reimbursement rates provided by the health insurance plans.**
Option VI:	**Include in the 2003 workplan for the Joint Commission on Health Care, further study and analysis of the issue of reimbursement of noncontracting ancillary services providers.**

Overall Summary of Comments

The four commenters supported Option I (Take no action).

Summary of Individual Comments

Medical Society of Virginia

Michael Jurgensen, Director of Health Policy, commented in support of Option I and in opposition to Options II-VI. Mr. Jurgensen stated: "MSV supports Option I: Take no action. We believe that the improved communication efforts among the parties involved (patient, physician, health plan, and hospital) can alleviate what appear to be relatively rare occurrences of this problem in Virginia. The legislative proposals presented in Options II through V appear to be excessive remedies for an issue that arises infrequently, as evidenced by the information from the Bureau of Insurance. Options III through V would also impose some significant costs on several of the parties in the form of mandated notices, mandated participation, and significant limitations on the ability of physicians, physician groups, hospitals, and health plans to negotiate reasonable contracts. As to Option VI, MSV does not believe a further study of this issue is necessary in 2003. Since the Bureau of Insurance already tabulates patient complaints, any increase in the incidence of this problem can be identified in their reports and, should a substantial increase occur, the need for further action could be determined at that time."

Virginia Association of Health Plans

Joy M. Bechtold, Director of Policy, commented in support of Option I and expressed opposition to the items proposed in Option III. Ms. Bechtold indicated:

"VAHP surveyed its membership on issues pertaining to SJ 125, and the findings were as follows:

- Each of the plans responding to the survey indicated that they are providing reimbursement for services rendered by non-contracting, hospital-based providers.
- It would not be useful to require plans to communicate the financial risk of being serviced by a non-contracting provider via a pre-authorization letter, as not all procedures requiring ancillary services require pre-authorization. Additionally, in cases in which pre-authorization is required, the notices are often sent directly to the provider.

Plan comments on issues related to SJ 125 also touched on the following points:

- Health plan networks are the only thing that stands between consumers and the full cost of health care. In the absence of provider networks, consumers would be responsible for the providers' total billed charges. Disincentives to join the network can (and will, as has been the case in Colorado) result in increased health care costs and reduced access for purchasers and consumers.
- While health plans expressed concern regarding provider consolidation within the health care marketplace, they are well acquainted with the complex dynamics of contract negotiations, and felt that any legislative solution would likely result in unintended consequences outweighing any perceived benefits."

Virginia Chapter American College of Radiology

Alan H. Matsumoto, M.D., President, commented in support of Option I. Dr. Matsumoto indicated:

"...most radiologists actively seek to participate in managed care networks. Participation in such plans works for the convenience of the radiologists as much as for their patients. Thus, radiologists make a good faith effort to participate in the plans that their hospitals have contracted with in order to complement those relationships. Nevertheless, there are rare circumstances where a radiology group has difficulty in negotiating fair contracts, and in those rare circumstances, contractual agreements may not have been reached. But these circumstances are very rare.

The excellent issue brief on this item reports no data indicating the extent to which hospital-based physician groups do not currently have contracts with managed care organizations that also contract with the host hospital. We expect if such a survey were performed, the result would be almost universal contracting, evidenced by the fact that, as reported in the issue brief, only two of sixty-three complaints to the Center for Quality Health Care Services complained of out-of-network billing of patients by hospital-based physicians. But without such data, we submit that any legislative initiative to mandate such contracts is not justified and could result in harmful, unintended consequences.

Radiology groups, both in community and academic medical practices, are experiencing a significant manpower shortage. If legislation were to be enacted to compel contracting and consequently make the bargaining position uneven between managed care plans and hospital-based physician groups, we fear that Virginia radiology groups will suffer and be

placed at a competitive disadvantage with other states in the recruitment and retention of new highly-trained radiologists.

We urge you to sustain the current free market that exist between insurers and hospital-based physicians."

Virginia Hospital & Healthcare Association

Katharine M. Webb, Senior Vice President, responded in support of Option I. Ms. Webb indicated that, "We continue to believe the best course of action is continued education and communication between and among patient enrollees, their physicians, their hospitals where they will have procedures performed, and their health plans. We are concerned about the unintended consequences of a legislative solution to this health care reimbursement issue given the many other very significant reimbursement problems that we face. With the Center for Quality Health Care Services and the Office of Managed Care Ombudsman both reporting that there are few complaints regarding the issue of reimbursement for noncontracting providers, this Association commits to continued discussions with the affected parties and strongly supports no legislative action."

JOINT COMMISSION ON HEALTH CARE

Executive Director

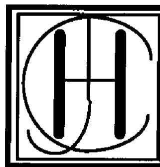
Kim Snead

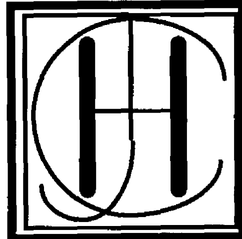
Senior Health Policy Analyst

April R. Kees

Office Manager

Mamie V. White





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