

Insurer Versus Provider

Out-of-network and PIP benefit caps would significantly impact health care community

By Brian Kalver, Michael F. Schaff, and Alyson M. Leone

The struggle between health care providers and insurers has a long and twisting history.

Insurers — a term that used generically to include health maintenance organizations, benefit plans and other third-party payers — use a range of tactics to limit the amount they pay out on claims for medical services, including medical necessity denials and other types of utilization review, coding reviews and edits, post- and prepayment audits, and in the managed care context, referral and precertification requirements. While insurers are obviously legally entitled and even obligated to use the insurance fund only for covered services, many have set up bureaucratic hurdles to payment that are complex and/or not transparent and in some instances extremely cumbersome.

Participating and nonparticipating providers regularly devote significant time and resources to getting their patients' claims processed, yet still frequently find themselves in a waiting game for payment.

Providers directly involved in submitting and pursuing collection on insurance claims increase their exposure to allegations of insurance fraud.

In recent years, New Jersey insurers, egged on by the Insurance Fraud Prevention Act, which permits insurers to recover treble damages and recoup costs, have become much more aggressive in playing the fraud card in disputes with providers. In cases where issues such as medical necessity and standard of care are not in dispute, it has become more com-

mon for providers to face accusations of insurance fraud based on purported violations of vague and confusing self-referral and licensure regulations, or for engaging in common business practices. Some have learned the hard way that ignorance of the law and "everybody does it" are not iron-clad defenses.

A provider who has had a particularly bad experience may extricate himself from the insurance claims process, bill patients directly and insist on payment at the time of service. Some aggressive policies of denying or delaying payment on claims based on submission requirements and medical necessity have, in large part, been the cause of various provider class action lawsuits against private health care insurers. Recent settlements may curtail some of insurers' more egregious policies and eliminate some of the mystery and frustration experienced by providers.

In addition to the tactics discussed above used by insurers to limit payments to providers, another powerful tool is the fee schedule. A true fee schedule is a feature of the insurance benefit that limits the payment for a particular type of service to a specified amount, without regard for what the provider charges for that service.

In the absence of a fee schedule, most health insurance policies limit payouts to "usual, customary and reasonable" (ucr) charges. While the precise meaning of the term ucr is subject to some interpretation, it is not set by the insurer, but rather is determined by reference to objective facts. Fee schedules can be used to support ucr limits in the insurance policy and avoid disputes over the methods for determining ucr. More often, fee schedules are used to bring insurance payments below (frequently far below) what typical providers have previously charged.

The fee schedules used by the Medicare program are required by federal law. The fee schedules that apply to the personal injury protection (PIP) medical benefits in New Jersey

automobile insurance policies are required by New Jersey law and are developed by the New Jersey Department of Banking and Insurance (NJDOBI). The Medicare and PIP fee schedules, in addition to limiting the amount the insurer must pay for medical services, limit the *total* amount that providers may collect from the insurer *and* from the patient for services covered by Medicare and the PIP medical benefit, respectively. In other words, providers (without regard to their participating or nonparticipating status) are prohibited from balance billing for covered services. The term "balance bill" is used in this article to refer to billing for the portion of the charge that is above the limit on covered charges imposed by the insurer, and not to limitations on payment under co-insurance, copayment or deductible provisions in the policy that allocate a specified portion of otherwise covered charges to the beneficiary.

Managed care health benefit plans also use fee schedules to limit their payments for medical services, but these private insurers do not have the power to unilaterally prohibit providers from balance billing the way that the federal and New Jersey governments have done for the Medicare program and PIP medical benefit. So, managed care plan fee schedules are, for the most part, only applied to participating providers who enter into a voluntary agreement with the insurer not to balance bill.

From the providers' perspective, fee schedules seem to make it easy for insurers to lower payments from year to year, or over time. Relatively small upward adjustments are sometimes made to the payment amounts on fee schedules to reflect inflation or cost increases. However, over the longer term, insurers have used fee schedules as a blunt tool to reduce payouts for medical services by making significant reductions to fee limits that do not require approval from, or even a formal notice to, providers.

Providers are particularly upset when the fee schedules of private

Kalver, Schaff and Leone are with Wilentz, Goldman & Spitzer of Woodbridge.

insurers track changes in the Medicare fee schedule. According to a recent American Medical Association press release, proposed reductions in payments by the Medicare program will reduce payments to physicians by 10 percent next year and 40 percent over the next nine years, while physician practice expenses will increase at a rate of about 2 percent per year.

Medicare is fundamentally not a market-driven insurance product and significant reductions in the Medicare fee schedule are made periodically based on the federal government's assessment of its own needs and political priorities. It is perhaps inevitable that the lower fees paid for medical services covered by Medicare will impact the overall market for medical services. However, providers believe that in tracking the generally downward trends of the Medicare fee schedule, insurers gain an unfair advantage and an opportunity to profit by passing along only part of the payment reductions to consumers.

The last bastion of freedom from fee schedules is the providers' ability to elect to stay out of private health insurance provider networks. While not economically feasible for many providers, as long as it is a serious option for a fair number of in-network providers, it provides what may be the only effective disincentive against insurers lowering fee schedules to a rock bottom level.

At the end of 2006, the NJDOBI proposed changes to its PIP regulations, and also to its health benefit plan regulations. The NJDOBI's PIP regulations, as noted above, already include a fee schedule for physicians' services, while the NJDOBI's health benefit plan regulations do not. The proposals, which are described in more detail below, would make use of the Medicare physician fee schedule as a reference for both PIP benefits and the out-of-network benefits provided by health benefit plans.

While the existing PIP fee schedule is already below what many providers think is reasonable, the NJDOBI's reliance on the Medicare fee schedule makes the future of fees for caring for automobile accident victims even more bleak. Out-of-network health benefits, on the other

hand, are currently largely free of any fee schedule, so NJDOBI's proposed change to the health benefit regulations is ominous both because it threatens providers' ability to avoid fee schedules entirely, and in particular because it uses the Medicare fee schedule.

In September 2006, the NJDOBI proposed updated fee schedules for the PIP medical benefit, including expanding the list of services on the fee schedule, most significantly by the addition of ambulatory surgery center (ASC) services.

The health care community in New Jersey is watching carefully as providers and insurers lay out their cases as to the benefits and detriments of the recent NJDOBI proposals.

Pursuant to N.J.S.A. 39:6A-4.6, which instituted the use of a PIP fee schedule in 1990, the PIP fee schedule is supposed to incorporate the prevailing fees of 75 percent of the practitioners within a region. According to NJDOBI, in preparing the currently proposed PIP fee schedule, it used the Medicare fee schedule amount to formulate the prevailing fee, but noted that it would not necessarily base future PIP fee schedules on the Medicare fee schedule. While the fees in the proposed PIP fee schedule are expressed in dollar amounts for each type of service, NJDOBI implies in its proposal that the fees are generally set at 130 percent of the Medicare fee schedule amount, with some exceptions made for particular services. The proposal also includes a new fee schedule for ambulatory surgery center services, with fees at 300 percent of the Medicare fee schedule for ASC services.

NJDOBI's proposal makes a number of other changes to the existing PIP fee schedule regulation, some of which are designed to reduce payments for particular services, or for services provided in particular circumstances. While these changes do not have the across-the-board impact of basing all fees on the Medicare fee schedule, they increase the economic pressure on providers to avoid treating automobile accident victims.

At the time of writing of this article, the NJDOBI appears to be poised to adopt its proposed PIP fee schedule this summer. However, a bill was introduced in the New Jersey legislature in March by Assemblymen Neil Cohen and Jon Bramnick that would prohibit NJDOBI from basing PIP fee schedules on Medicare methodology and require NJDOBI to go back to the drawing board to update the current PIP fee schedule.

In December 2006, NJDOBI proposed changes to its health benefit plan regulations to allow private health insurers to issue policies that limit payments for out-of-network nonhospital providers' services by imposing a cap on payments for covered services. The cap would have to be at or above 150 percent of the Medicare fee schedule amount. While nothing in the law or regulations clearly prohibits private insurers from imposing this sort of limit on out-of-network payments, such a limit would represent a tremendous departure from the current norm. This would vastly complicate the calculation process that consumers go through when determining whether to seek care from out-of-network providers, as well as calculations by out-of-network nonhospital providers in their dealings with patients and insurers.

In the first instance, 150 percent of Medicare rates is far below what most out-of-network providers currently charge (and are paid) for their services, and the disparity becomes significantly greater for providers who avoid networks altogether. Secondly, the history of fee schedules in general (and the Medicare fee schedule in particular) is that over time they are used to limit payments so that they are well below what the

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market would otherwise bear.

As noted above, while in-network providers are prohibited by contract (and regulation) from balance billing, private health benefit plans do not have the power to prohibit out-of-network providers from balance billing. A provider's decision as to whether and how to balance bill patients is a highly individualized decision, based on a number of factors, including the size of the balance and the relationship between the provider and the patient. Based on generalities, such as the typical balance sizes and the sort of relationship that the provider generally wants to maintain with patients, providers develop policies that range from never bothering with balances to aggressively pursuing collection on balances the way a finance company might on a consumer loan.

NJDOBI's health insurance proposal appears to curtail insurers' ability to set limits on payments for out-of-network services that are lower than the Medicare limits. However, out-of-network nonhospital providers (principally physicians) have objected to the proposal, voicing skepticism as

to the need for a regulatory floor on nonexistent out-of-network fee schedules. Instead, the providers anticipate that the fee schedule would work as a ceiling, acting as a blueprint for private insurers to quickly and aggressively market plans that do just what the regulation allows — limit out-of-network payments to 150 percent of Medicare rates. This would circumvent the otherwise inevitable and lengthy debate over the impact that such plans will have on consumers (and providers) and the guidance that consumers will need to understand this change.

Capped benefits may be likely to result in lower premiums (to the extent that the savings are not used to increase insurer profits), but they also stand a good chance of wreaking havoc on the overall health insurance system. By significantly reducing out-of-network benefits, insurers will succeed in pressuring many of the consumers who use their out-of-network benefits to switch to in-network providers. This may push more non-participating providers to join networks, which, at first blush, would be good for consumers. But it also may come at a high price to consumers as

more out-of-network providers leave New Jersey or limit their practice to the wealthiest residents, and the state becomes a less attractive home for top-notch physicians.

Adoption of the out-of-network benefits proposal does not appear likely any time soon, although as of this writing NJDOBI has not withdrawn the proposal. Similar to their bill regarding the PIP fee schedule, Assemblymen Cohen and Bramnick have introduced *A-4075*, which would counter the effects of NJDOBI's health care proposal, prohibiting private health insurance companies from basing out-of-network fee limits on the Medicare fee schedule. This bill would also require health insurance carriers to use billed (rather than paid) charges as the basis for its out-of-network fee schedule.

The health care community in New Jersey is watching carefully as providers and insurers lay out their cases as to the benefits and detriments of the recent NJDOBI proposals discussed above. Many providers believe the skirmish over fee schedules may represent a particularly significant setback in the overall fight. As PIP fees drop, and out-of-network coverage loses its value, many providers may look for ways to work entirely outside of the insurance system, or give up the battle and leave New Jersey or retire early. ■

Liability for Substandard Services

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cal in today's environment in which prosecutors are actively searching for viable qui tam actions and federal prosecutions. FCA actions premised on debatable standards of care not mandated by regulation appear problematic. Usage of FCA as a potent government tool is here to stay. Thus, the Deficit Reduction Act of 2005 (DRA), Pub. L. 109-171, Section 6032, mandates that certain health care entities conduct educational programs alerting their employees and vendors to their whistleblower rights

under FCA and encouraging states to enact their own FCA statutes through financial incentives.

Facilities such as nursing homes, long-term care entities and hospitals need to be aware that a qui tam whistleblower action under FCA can be filed with the court secretly and permits thereby an undercover use of the whistleblower employee to gather evidence on the job before any legal action is evident. Therefore, systematic patient safety and compliance measures need to be fostered and employees encouraged to voice safety or quality of care concerns

without retribution. Preventing the creation of whistleblowers in the first place enhances the goal of patient safety and quality care and the horror of FCA prosecution, which can ruin both facilities and their management. Along with these internal approaches, education of management on the current status and seriousness of FCA prosecutions by counsel is critical. Beyond anything else, the moth-eaten blankets and defective munitions from 1863 that gave rise to the FCA are ghosts that still haunt health care and government contracting with a vengeance. ■