2017 REPORT OF THE DEPARTMENT OF CONSUMER AND BUSINESS SERVICES REGARDING REIMBURSEMENT OF SERVICES PROVIDED TO ENROLLEES BY OUT-OF-NETWORK PROVIDERS AT IN-NETWORK HEALTH CARE FACILITIES

In Accordance with House Bill 2339 (2017)

EXECUTIVE SUMMARY

On June 22nd, 2017, Governor Kate Brown signed House Bill 2339 into law. This bill, pre-session filed for the Department of Consumer and Business Services, prohibits out-of-network health care providers from balance billing patients covered by health benefit plans or health care services contractors for services provided at an in-network health care facility.

Once consumers were removed as a source of reimbursement for out-of-network bills[1], the crucial component of the legislation focused on what would constitute a reasonable substitute for a negotiated rate of reimbursement, in lieu of a contract between the commercial payer and the provider. As the Legislative Assembly deliberated on the passage of the bill, two methods of determining reimbursement were discussed and ultimately rejected. One method would have codified a percentage of Medicare reimbursement rates (175% of Medicare was the last iteration of this method). The other method would benchmark reimbursement to a percentage of billed charges, as recorded in a database maintained by a not-for-profit entity.

As the Assembly identified challenges in both approaches, the enrolled bill directed DCBS to convene an advisory group that included health care providers, insurers and consumer advocates to develop recommendations for the reimbursement of services provided to enrollees by out-of-network providers at in-network health care facilities. The advisory group was directed to provide its recommendations to the director of DCBS, and the director to report these recommendations to the Legislative Assembly no later than December 31, 2017. This report will update the Legislative Assembly on the advisory group process and the future work ahead.

OUTCOME OF ADVISORY GROUP

The advisory group has made significant progress on this issue. One key question answered was the use of APAC as a source of information. As the starting point of a benchmark was a topic of great concern during the deliberation of the bill, getting to APAC is an achievement. The advisory group did recommend that, regardless of the final methodology, reimbursement for these claims should vary by geographic region. The advisory group recommended that additional precautions be taken so as to not reveal competitive

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information. Also, from the voting patterns it is clear that there are many common elements that the workgroup may agree on in principle, but not necessarily in detail. These elements will be useful as the department continues its work to solve the issue.

However, any viable recommendations for legislation should result from a carefully negotiated solution with levels of approval or neutrality from all parties involved. Because we were unable to achieve that negotiated solution in the time allotted, DCBS is not able to provide a clear recommendation for legislative change to the Legislative Assembly at this time.

NEXT STEPS

It needs to be said that the department is concerned about the fact that it could not reach a negotiated solution with all parties involved. The department is particularly concerned of the downstream effects on consumers while providers, facilities and carriers continue complex negotiations regarding reimbursement, of which 3-5% of cases are covered by the provisions of HB 2339. But consumers are protected by what the bill centrally set out to achieve – i.e., to keep consumers generally out of the balance billing process. The division will take a dim view toward potentially narrower networks, which may be addressed through other provisions of law.

As DCBS requested this bill, it is up to the department to continue the good faith discussions between interested parties to find a solution. Fortunately, progress has been made in identifying a data source and identifying elements that could bring the parties to a common understanding. It is the department's commitment to continue to craft reimbursement rates that fairly compensate providers while encouraging robust insurance networks, all the while keeping surprises to the consumer at a minimum.

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DEPARTMENT OF CONSUMER AND BUSINESS SERVICES
REGARDING REIMBURSEMENT OF SERVICES PROVIDED TO ENROLLEES BY OUT-OF-NETWORK PROVIDERS AT IN-NETWORK HEALTH CARE FACILITIES

TO

THE SEVENTY-NINTH LEGISLATIVE ASSEMBLY

In Accordance with House Bill 2339 (2017)

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BACKGROUND

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As the Assembly identified challenges in both approaches, the enrolled bill directed DCBS to convene an advisory group that included health care providers, insurers and consumer advocates to develop recommendations for the reimbursement of services provided to enrollees by out-of-network providers at in-network health care facilities. The advisory group was directed to provide its recommendations to the director of DCBS, and the director to report these recommendations to the Legislative Assembly no later than December 31, 2017. This report will update the Legislative Assembly on the advisory group process and the future work ahead.

ADVISORY GROUP MEMBERS

Section 3(1) of HB 2339, directed the department to convene an advisory group consisting of "health care providers, insurers and consumer advocates." As the department has been engaging in robust discussions since fall 2016, the department extended an invitation to the interested parties already working through issues with the bill. Advisory group members were as follows:

[1] Under 2339, patients are still generally responsible for deductibles, co-insurance, co-payments and other cost sharing mechanisms.

Consumer Representatives:

- Jon Bartholomew, American Association of Retired Persons
- Jesse O'Brien, Oregon State Public Interest Research Group

Insurer Representatives:

- Jennifer Baker, Cambia Health
- Elise Brown, America's Health Insurance Plans
- Amy Fauver, Kaiser Permanente
- Lisa Hynes, Health Net Health Plan of Oregon
- Geoff Knapp, PacificSource Health Plan
- Megan Lane, Providence Health Plan
- Dave Nesseler-Cass, Moda Health Plan

Provider Representatives:

- Kathy Brown, Oregon Association of Orthopedic Surgeons
- Courtni Dresser, Oregon Medical Association
- Michele Kimbal, Physicians for Fair Coverage
- Sean Kolmer, Oregon Association of Hospitals and Health Systems
- Sabrina Riggs, Oregon Society of Anesthesiologists
- Patty O'Sullivan, College of American Pathologists
- Chris Strear, Oregon Chapter of the American College of Emergency Physicians

ADVISORY GROUP PROCESS

The advisory group convened five times between August and November and had the opportunity for discussion during the scheduled meetings. The level of participation in discussion varied greatly with some stakeholders participating in the discussions infrequently. Advisory group members proposed and rejected a number of concepts during the various discussions. Every meeting was held in Salem and was open to the public. The meetings were live streamed and recorded. The recordings, in addition to all meeting materials, public comments received and committee member information are available at: http://dfr.oregon.gov/community/committees-workgroups/Pages/balance-billing-rac.aspx.

Meeting #1: Background, Charter and Presentation on Oregon's All Payer All Claims Database

In their first meeting the advisory group reviewed and adopted their charter. The advisory group also received a presentation from Oregon Health Authority staff on the state's All Payer All Claims (APAC) Database. Oregon's APAC is a large database that houses administrative health care data for Oregon's insured populations. It includes medical and pharmacy claims, enrollment data, premium information, and provider information for Oregonians who are insured through commercial insurance, Medicaid, and Medicare.

The Oregon State Legislature established APAC in 2009 as a tool to measure health care costs, quality, and utilization, and commissioned the Oregon Health Authority (OHA) to

operate the database. An integral component of the state's ongoing health care improvement efforts, APAC provides access to timely and reliable data essential to improving quality, reducing costs, and promoting transparency.

The division made the determination when forming this advisory committee to develop a reimbursement methodology based on APAC data. In this and subsequent meetings, the division and advisory committee members discussed how (not whether) to use APAC data.

Meeting #2 & #3: Discussions on the Use of APAC and Other Reimbursement Methodology Considerations

In the second and third meetings, to gain more information from members on concepts that the advisory group was unable to address fully (or had been discussed without concrete resolution), advisory group members were sent email surveys. From these surveys the division constructed a proposed resolution that accounted for concerns and requests of all parties. In their second meeting, the advisory group also received an update on the availability of APAC data, followed by a discussion on the use of APAC. The survey question in the second meeting was developed in the course of identifying data sources for recommendations on the reimbursement methodology, including APAC.

The advisory group discussed such topics as whether specific classes of payers be included or excluded as a variety of payers submit data to APAC. The advisory group also discussed how it may address claims regarding substance use disorders, which unlike claims data for most CPT codes is not available in APAC, CPT codes for substance use disorders are protected under federal regulation and in turn excluded from APAC reporting. Lastly, the advisory group discussed addressing geographic differences in medical costs in the recommendation. In their third meeting the advisory group reviewed APAC data further as well as the results from the second set of survey questions developed by DCBS staff to inform the recommendations. While the division did not ask for individual statements of preference from committee members, deliberations during the passage of the bill had already led to a general consensus to explore APAC as a data source.

Reimbursement Methodology Issues and Considerations

Between the second and third meetings a number of considerations pertaining to APAC-related variables were considered and discussed. Although advisory group discussions were intended to be focused on the use of data from Oregon's All Payer All Claims (APAC) database, some advisory group members continued to suggest use of FAIR Health[2] or Medicare-based models, billed charges data supplied by FAIR Health[3] or Medicare-based models. Previous discussions on Medicare and Fair Health were not revisited because various stakeholders and previously objected to each methodology during the legislative process. The division was instead tasked with looking at APAC as a third way option for

[2] https://www.fairhealth.org/about-us
[3] https://www.fairhealth.org/about-us

reimbursement methodology. The range of topics pertaining to the use of APAC data and other reimbursement methodology considerations more generally, included the following:

Which year's data to use and how to manage the data lag. According to APAC administrators, the data has an extended reporting and validation timeline, and is governed by a developed process. The advisory group also discussed whether an adjustment factor, such as medical inflation or the Consumer Price Index, should be used to account for the two-year lag between the APAC claims data and the date services are rendered. At least line of discussion suggested that the division base the methodology on the latest available data and then adjust for CPI.

Advisory group members also discussed the need for an authoritative entity, such as DFR, to determine which version of APAC data payers should be using at a given point in time to ensure accurate reimbursements.

***What combination of payer data to use*.** APAC data includes health claims from the commercial market, as well as Medicare and Medicaid reported data. Self-insured ERISA plans are invited to submit data voluntarily, but are not mandated to do so. Inclusion or exclusion of a particular type of data alters the reimbursement amount for each procedure. The main point of discussion on this point was whether to include Medicare and Medicaid claims data or base the reimbursement off commercial data only. Some advisory group members advocated for a more broad-based data set that reflects all payers in the market (and likewise all reimbursements accepted by providers in the market) while others recommended the use of commercial data only.

The workgroup did discuss whether to include health claims data from Medicare and Medicaid reported data, and at least one instance more parties than not expressed preference for excluding the data. But consensus on this point was not consistent or sustained.

How to address unreported Current Procedural Technology (CPT) codes[4]. The advisory group specifically looked at substance use disorder codes that are exempt from reporting to APAC under federal law. The group also discussed how to deal with new CPT codes that have been released during the "claims lag" and are not included in the most recent APAC data set. Carriers proposed, among other things, a "fall back" data source (such as Medicare data) for these instances when there is no data (or not enough data to be statistically credible) for a specific CPT code. The advisory group concluded that the frequency of these codes would be low, but did not come to a consensus on a specific plan for handling this type of claim. Providers did agree to one particular portion of reimbursement proposed by the division, which would have reimbursed such codes to 75%

[4] Current Procedural Terminology (CPT) is a medical code set that is used to report medical, surgical, and diagnostic procedures and services to entities such as physicians, health insurance companies and accreditation organizations. CPT codes are used in conjunction with ICD-9-CM or ICD-10-CM numerical diagnostic coding during the electronic medical billing process.

of the billed amount, there were other issues associated with the division's proposal that necessitated more discussion.

CPT Code Modifiers. Modifiers are used in addition to a CPT code to add more information to a claim. These modifiers communicate special circumstances that affect the amount the provider will be reimbursed. Some specialties rely more heavily on the use of modifiers than other providers. Global billing and how it is subsequently reported to APAC might also influence the data on CPT codes. Pathologists seemed the most interested in the impact inclusion of the modifiers "26" and "TC" (technical component) would have.

Geographic Price Variation. Medical price variation due to a number of factors is widely recognized by health care stakeholders. As such, the advisory group considered whether reimbursement rates should vary by geographic region. Some providers expressed concern that if rural rates were inadequate, some provider groups might leave the area. Conversely, some insurers were concerned that in areas with limited insurer participation there might be a way to reverse engineer contracted provider rates when based on a geographic rating area. As the division looked further into the issue, it became clear that reverse calculating rates could be challenging, particularly due to blind spots of ERISA data and other factors. However, the advisory committee did come to a general consensus that reimbursement rates should vary by geographic region, but did not settle on what the variation should be (by county, Geographic Rating Area, etc.).

Reimbursement Amount Basis. Technical considerations regarding the basis for the reimbursement were also made. These included whether a percent, percentile, median or average of the data should be used. Further, there was robust debate during several meetings to determine whether the reimbursement amount should be based on the amount providers bills insurers for services (i.e. billed amount) versus the maximum amount insurers are willing to pay – or have negotiated to pay – for a covered health care service (i.e. allowed amount, paid amount, eligible expense, negotiated rate).

Dispute Resolution. The advisory group reassessed the need for a dispute resolution process between providers and insurers. The introduced version of the bill required insurers to establish a dispute resolution process, but had been amended out by the time the A-engrossed version was printed. The discussions were part of a broader discussion on ensuring that the prohibition on surprise billing were held to an enforceable standard. Discussion also touched on whether dispute resolution would be necessary if a reimbursement rate was fair and transparent. The committee came to a general consensus that, if a clearly defined reimbursement rate was established, then a dispute resolution process would not be necessary.

Implementation Timeline. HB 2339 bans balance billing as of March 1, 2018. The division had intended this bill to be passed and the reimbursement methodology established for a March 1 effective date. Insurers raised concerns that establishing a reimbursement rate by March 1, 2018 would not be feasible. The division notes that stakeholders' concerns with implementation timelines have vacillated from the time the bill was discussed at the Assembly to the time the workgroup discussed the issue. System programming issues

needed to implement changes in claim processing might be an example of a barrier to complying with a March 1, 2018 effective date.

Data Source. Insurers, late in the process, raised additional implementation concerns relating to the integration of APAC data into their payment systems. Each APAC quarterly update includes new claims and a refreshed set of claims submitted in the previous three quarters. Insurers urged the division to determine how DCBS could periodically pull the data insurers would be instructed to use to ensure all insurers are using the same data set.

Network Adequacy. A reoccurring discussion item was the narrowing of networks and the contribution of this phenomenon to the balance billing issue. The advisory group also considered making a recommendation to the legislature to establish additional network adequacy reporting requirements. Insurers pointed to existing network adequacy requirements to which they are accountable. Insurers requested more detail about a proposed report to the division on the network adequacy requirement.

Accountability For Providers And Insurers. The advisory group discussed and generally concurred on the need to ensure the law is put into practice, but the division raised concerns that an enforcement process for providers failing to follow the ban on balance billing falls outside of the scope of their jurisdiction. The division can and should facilitate discussions with the Oregon Health Licensing Office, but there is no guarantee that the result of those discussion would lead to enforcement activity. Insurers noted that they are bound by all provisions in the Insurance Code (including a reimbursement methodology) and the division has a number of existing enforcement mechanisms to use against insurers for noncompliance.

Meetings #4 & #5: Narrowing Down Potential Options. At the fourth meeting, the division put forth a proposal based on survey responses:

1. Strengthen network adequacy reporting.
    a. Require insurer to provide a full list of provides that they have been unable to reach agreements with, regardless of the cause of contract negotiation breakdowns.
    b. Work with provider licensing boards and insurers to determine source of contract negotiation concerns and opportunities for increased networking.
2. Establish a consistent and transparent reimbursement rate for providers subject to surprise billing prohibition.
    a. 100 percent of the Allowed Amount for in-network services based only on-network commercial data as reported to APAC.
    b. Account for lags in APAC data by adjusting for CPI.
    c. Unreported codes are paid at 75 percent of the billed amount.
3. Protect consumers.
    a. Hold consumers harmless.

The division understood that the bill did not require complete consensus on all points, but if recommendations were to result in actionable legislative proposals, the workgroup needed to get as close as possible to consensus.

However, this proposal was rejected by a majority of advisory group members. Reimbursement was acceptable to some parties, but the rest of the proposal had various issues that prevented it from being moved forward. Due to continued lack of consensus, members were asked to narrow the field of options by an elimination vote. Although some members objected, this process allowed DCBS to narrow the field of options. Nonetheless, the advisory group ultimately did not reach a consensus recommendation.

The final options considered by the advisory group were:

Option 1. Reimbursement at the average between the 80th percentile of the allowed amount and 80th percentile of billed amounts.

Option 2. Reimbursement at 80% of the average allowed amount for all claims data available in APAC, including commercial, Medicare and Medicaid claims.

Option 3. Reimbursement at 100% of the median allowed amount as shown in APAC for commercial claims only.

Option 4. Reimbursement at 125% of the average allowed amount for commercial claims reported to APAC for 2015, adjusted annually for inflation.

The division held two rounds of votes – Option 1 versus 4 and Option 2 versus 3. Option one was eliminated in its contest against Option four. The advisory group was then asked to vote their preference between Option 2 and Option 3. The final tally of these votes had eight members supporting Option 3, six members supporting Option 2, one member not responding and one member electing not to vote. The advisory group also was asked to vote "yes" or "no" on whether to include Medicare and Medicaid claims data. These votes were also split with six members voting "yes," eight members voting "no," one member not responding and one member electing not to vote.

On the vote taken to gauge interest in whether reimbursement methodology include all payers, options 2 or option 3, the votes were generally Option #3 (8); Option #2 (6); Non-votes (2).

The advisory group initially recommended that these votes be included in this report. However, for the sake of brevity the division has elected to summarize the results of the vote. All votes and responses are a matter of public record, however, and will be made available upon request.

The advisory group then took a second vote on their preference between the previous contest winners – Option #3 and Option #4. Option #3 received 6 votes, and option #4

received 4 votes. This round of straw polling also had 6 abstentions. This resulted in a 6 to 4 win for Option 3, with 6 committee members not voting.

OUTCOME OF ADVISORY GROUP

Despite the 6-4 outcome, the division feels that there is not a clear consensus among advisory group members as to a single recommendation on reimbursement. Any viable recommendations for legislation should result from a carefully negotiated solution with levels of approval or neutrality from all parties involved. Because we were unable to achieve that negotiated solution in the time allotted, DCBS is not able to provide a clear recommendation for legislative change to the Legislative Assembly.

But the advisory group has made significant progress since its formation. One key question answered was the use of APAC as a source of information. As the starting point of a benchmark was a topic of great concern during the deliberation of the bill, getting to APAC is an achievement. The advisory group did recommend that, regardless of the final methodology, reimbursement for these claims should vary by geographic region. The advisory group recommended that additional precautions be taken so as to not reveal competitive information. Also, from the voting patterns it is clear that there are many common elements that the workgroup may agree on in principle, but not necessarily in detail. These elements will be useful as the department continues its work to solve the issue.

Finally, the advisory group recommended that this report include an illustrative example of reimbursement using the APAC data. This example – offered for illustration purposes only – is attached as Appendix A to this report.

NEXT STEPS

It needs to be said that the department is concerned about the fact that it could not reach a negotiated solution with all parties involved. The department is particularly concerned of the downstream effects on consumers while providers, facilities and carriers continue complex negotiations regarding reimbursement, of which 3-5% of cases are covered by the provisions of HB 2339. But consumers are protected by what the bill centrally set out to achieve – i.e., to keep consumers generally out of the balance billing process. The division will take a dim view toward potentially narrower networks, which may be addressed through other provisions of law.

As DCBS requested this bill, it is up to the department to continue the good faith discussions between interested parties to find a solution. Fortunately, progress has been made in identifying a data source and identifying elements that could bring the parties to a common understanding. It is the department's commitment to continue to craft reimbursement rates that fairly compensate providers while encouraging robust insurance networks, all the while keeping surprises to the consumer at a minimum.

The department stands prepared to brief the appropriate committees with jurisdiction over health care matters to answer questions and provide additional information.

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APPENDIX A: ILLUSTRATIVE EXAMPLE OF REIMBURSEMENT USING APAC DATA

2015 Median Claim Amounts - In Network

11/30/2017

Selected CPT Codes per Rating Area

	Oregon Rating Area						
CPT Code & Label	**1**	**2**	**3**	**4**	**5**	**6**	**7**
00790 - Anesth, surg upper abdomen	$ 871	$ 1,048	$ 741	$ 1,035	$ 1,020	$ 935	$ 918
00810 - Anesth, low intestine scope	$ 356	$ 443	$ 320	$ 523	$ 320	$ 378	$ 485
00840 - Anesth, surg lower abdomen	$ 790	$ 913	$ 653	$ 900	$ 884	$ 838	$ 868
88305 - Tissue exam by pathologist	$ 110	$ 126	$ 84	$ 126	$ 126	$ 138	$ 163
88342 - Immunohisto antb 1st stain	$ 96	$ 105	$ 78	$ 149	$ 114	$ 130	$ 99
99203 - Office/outpatient visit new	$ 195	$ 225	$ 188	$ 201	$ 188	$ 188	$ 219
99204 - Office/outpatient visit new	$ 296	$ 332	$ 286	$ 311	$ 286	$ 286	$ 340
99222 - Initial hospital care	$ 263	$ 268	$ 253	$ 271	$ 260	$ 242	$ 281
99223 - Initial hospital care	$ 412	$ 406	$ 366	$ 428	$ 383	$ 366	$ 391
99284 - Emergency dept visit	$ 256	$ 310	$ 363	$ 454	$ 455	$ 403	$ 432
99285 - Emergency dept visit	$ 365	$ 350	$ 365	$ 668	$ 496	$ 535	$ 467

Source: All Payer All Claims (APAC) database