New NASHP Model Legislation: Limiting Out-of-Network Provider Rates to Lower Costs & Increase Network Participation

November 29, 2022

NASHP | NATIONAL ACADEMY FOR STATE HEALTH POLICY

nashp.org

Model Legislation and Resources

The National Academy for State Health Policy has developed these model laws and resources to help states address rising health care costs. Accompanying each model act are additional resources, including in-depth analysis, Q&As, and examples of bills already approved by state legislatures across the country. To request additional resources – available only to state officials – please email mhq@nashp.org.

- + Anticompetitive Health Plan Contracts
- + Using Insurance Rate Review to Control Costs
- + Hospital Financial Transparency
- + Facility Fees
- + State Purchasing Pool Buy-in
- + Improved Oversight of Provider Mergers
- + Out-of-Network Provider Rate Limits

Model Legislation: An Act to Limit Out-of-Network Provider Rates

Q&A: Model State Legislation to Limit Out-of-Network Provider Rates

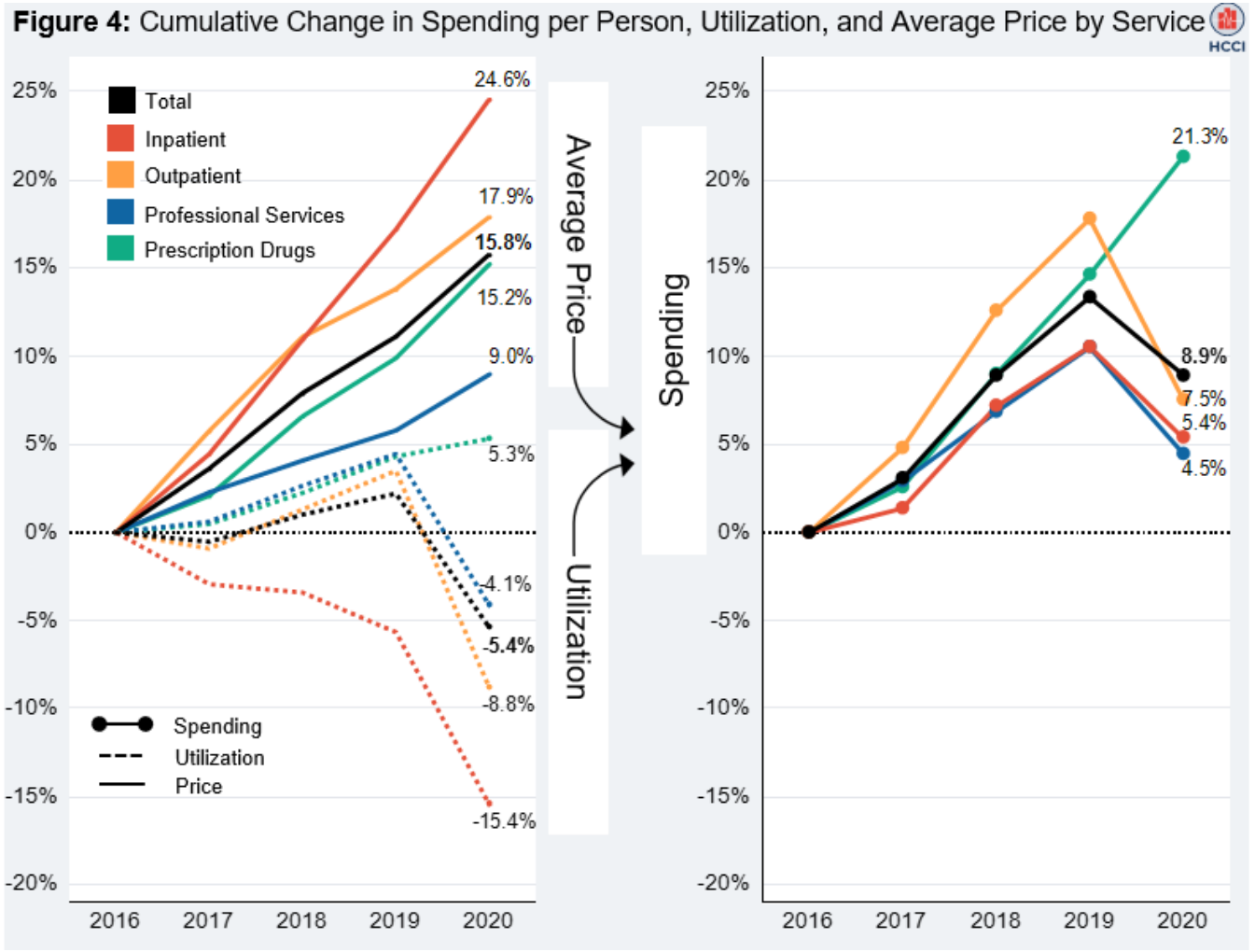
Speaker Overview

Moderator: **Maureen Hensley-Quinn**, Maureen Hensley-Quinn, Senior Program Director, Coverage, Cost & Value, NASHP

- **Michael Chernew**, Leonard D. Schaeffer Professor of Health Care Policy and Director, Healthcare Markets and Regulation Lab, Department of Health Care Policy, Harvard Medical School
- **Robert Murray**, President, Global Health Payment LLC
- **Erin Fuse Brown**, Catherine C. Henson Professor of Law and Director, Center for Law, Health & Society, Georgia State University
- **Margaret Smith-Isa**, Program Development Specialist, Oregon Public Employees' Benefit Board & Oregon Educators' Benefit Board, Oregon Health Authority

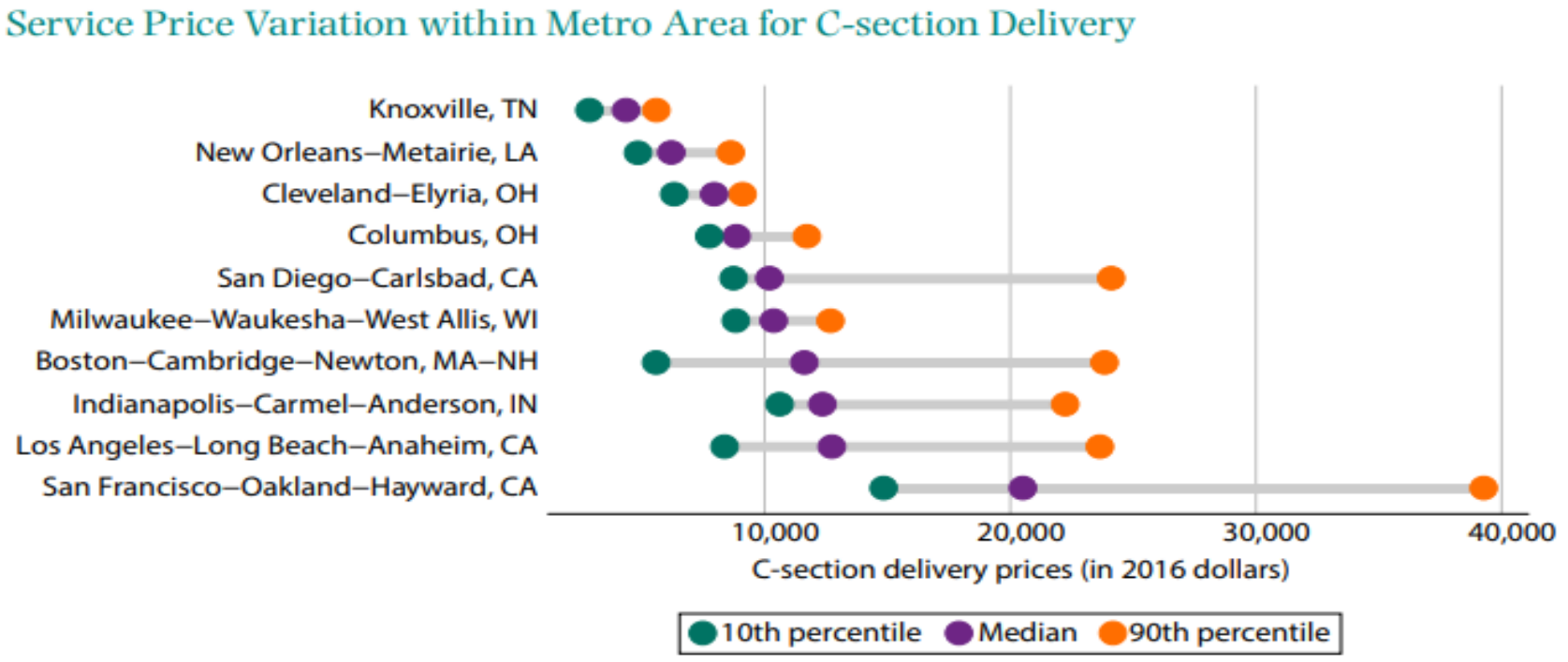
Michael Chernew, Leonard D. Schaeffer Professor of Health Care Policy and Director, Healthcare Markets and Regulation Lab, Department of Health Care Policy, Harvard Medical School

Increases in Spending Growth Driven by Price Growth



Health Care Cost Institute "2020 Health Care Cost and Utilization Report", published May 2022
https://healthcostinstitute.org/images//pdfs/HCCI_2020_Health_Care_Cost_and_Utilization_Report.pdf

Cross/ Within Market Price Variation



Source: Adapted from Kennedy et al. (2019) using Health Care Cost Institute data.

Notes: Percentiles (10th, median, 90th) show within-metro variation in price for the indicated service. Metro areas are defined as the 112 core-based statistical areas in the United States. A select group of metro areas is shown.

THE HAMILTON PROJECT
BROOKINGS

Wide price variability within and between markets

Generally 2-4x (up to 7x for within)

Pro-Competitive Strategies Face Challenges

- Markets are consolidated
- Few patients shop
  - High priced providers in ‘competitive’ markets
  - Even with transparency data
- Antitrust enforcement is important but:
  - Uncertain/ Slow/ Often too late

➔ Price regulation can help

Approaches to Price Regulation

- **Market Wide:**
  - Wide reach
  - Complex design and enforcement because payment units vary (DRG; % of charges; bundled payment; revenue codes)
- **Out-of-network:**
  - Narrower reach; but spillovers will magnify impact
    - Magnitude of spillover is crucial but unknown
  - Easier to implement

A Penny Saved is a Penny Lost

- The stronger the price regulation the bigger the revenue loss for providers

➔State employees vs whole commercial market

➔Cap vs set

Robert Murray, President, Global Health Payment LLC

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Background and Theory

- Intended to correct a pervasive **"negotiating/market failure":**
  - Hospitals leverage a threat to cancel a contract and be paid very high OON rates, as a strategy to get higher in-network negotiated (INN) rates
  - Thus, OON services account for a small proportion of services – but this is because most hospitals use this strategy to be "in-network" but at high INN rates
- OON Price Caps can both truncate high OON prices but more importantly have a positive "spill-over" impact on INN rates
- **Spill-over Dynamic:** should allow insurers to negotiate INN rates at/near the OON Cap or cancel the contract and pay a provider the OON Price cap (reverses the leverage)
- Empirical evidence to support concept:
  - Medicare Advantage program (INN rates at or near TM Medicare prices) (Berenson et al.)
  - State experience with caps on OON surprise bills (LaForgia et al.)

Advantages/Modeling Results of this Approach

- Approach has the advantage of only regulating a small proportion of service prices (only OON) 2-8% of all services
  - Allows for market negotiations for INN rates and continued development of Alternative Payment Models
  - Could be a “low-intensity” regulatory strategy but with a large impact on INN rate levels
- RAND report (using Medicare Cost Report data) showed an OON Cap at 200% of Medicare could realize $81 billion in spillover savings on INN hospital rates (7% private spending)
- Prager/Tillipman working paper/study (using State APCDs) also determined the potential for spill-over in-network savings
- Advocate a strategy of gradually declining OON Price Caps - could be effective to gradually reduce INN rates at the state level while the state monitors impacts

Caveats/Questions

- MA experience may not be 100% generalizable to the commercial market
- Network adequacy requirements may reduce plan negotiating leverage even with OON Caps (e.g., MA Dialysis providers have rates @ 130% of Medicare)
    - But this may be the exception that proves the rule vs. commercial rates 150-240% of Medicare
- Danger that highly dominant/"must have" providers could convince employers to insist insurers grant in-network status even at high rates (above OON Cap)
- Prager/Tillipman note there may be a tradeoff re: the level of OON Price cap and diminished network
- **Remaining Questions:** What authority is needed, what level to set the Price cap (modeling can assist states) and how to best benchmark Price Caps? And how to ensure savings from lower INN rates are passed on?
- **Overall:** A strategy of gradually declining OON Price Caps could be effective to gradually reduce INN rates while allowing monitoring of impacts

NASHP Model Act to Limit Out-of-Network Provider Rates

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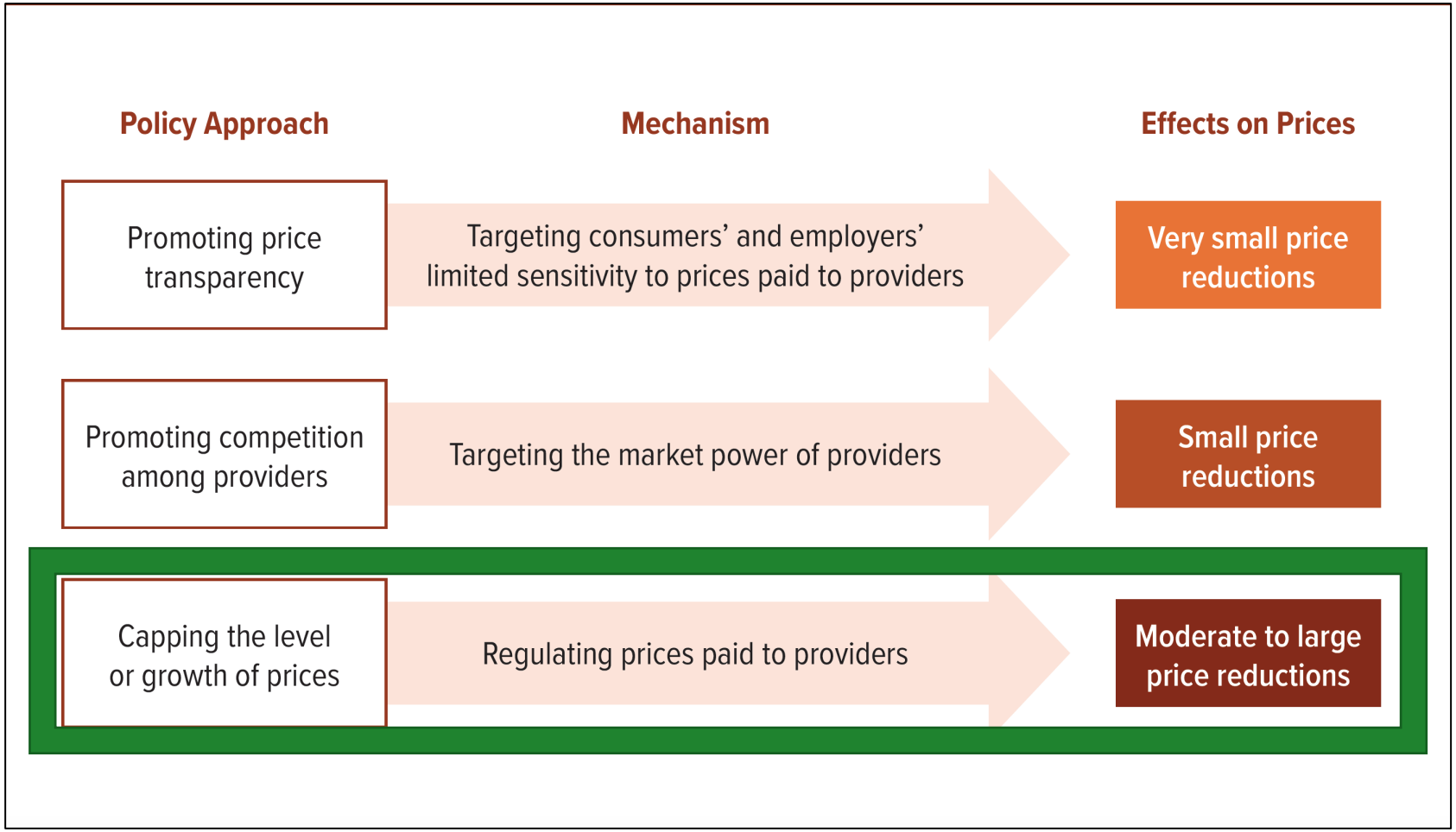
CBO boils health policy down to 1 slide



Source: Congressional Budget Office, Policy Approaches to Reduce What Commercial Insurers Pay for Hospitals' and Physicians' Services (Sept. 2022)

Menu of State Policy Tools to Control Health Care Costs

Policy Approach	Tools
1. Gather data	• All-payer claims databases • Enhanced hospital financial reporting and hospital cost analysis*
2. Active state purchasing	• Reference-based pricing for state employee health plan* • Renegotiate/Re-procure state employee PBM contract*
3. Mitigate consolidation and abuses of market power	• Pre-transaction review and approval * • Banning anticompetitive health insurance contract terms* • State AG action against anticompetitive conduct
4. Oversee health care cost growth	• Health care cost growth benchmarks*
5. Regulate provider rates	• Health insurance rate review – affordability standards* • Limit outpatient facility fees* • **Out-of-network rate limits*** • Public option • All-payer model, global hospital budgets

* NASHP model law, toolkit, or resources available at nashp.org/policy/health-system-costs/

What is in NASHP's Model Law?*

- It limits out-of-network rates for inpatient and outpatient hospital services to the *lesser of*:

  (a) The state's median in-network commercial rate for the same service; or

  (b) [X]% of the Medicare rate for the same service in the same geographic area

- **Applicability:** all health care providers that provide inpatient or outpatient hospital services (but does not currently include physician services) covered by a health benefit plan, which includes both state-regulated health plans and ERISA plans.
- **Administration:** administered by a state's health cost commission or other health agency with assistance from the Department of Insurance and Attorney General for data collection and enforcement.

* NASHP Model Act to Limit Out-of-Network Provider Rates, available at https://www.nashp.org/nashp-model-act-to-limit-out-of-network-provider-rates/

What data does a state need?

- **From Providers:** data on negotiated rates and claims paid to calculate median and growth rates of in-network and out-of-network hospital payments.
  - Resources: state APCD, Hospital Price Transparency Rule, other data requested by Health Cost Commission.
- **From Health Carriers and Plan Administrators:** data on negotiated rates and claims paid to monitor compliance with out-of-network rate limits, Medical Loss Ratios, Premium growth rates.
  - Resources: Department of Insurance, state employee health plan, Transparency in Coverage Rule
- **From Health Cost Commission:** annual report on trends in provider in- and out-of-network participation, rates, premiums, access, and compliance. Could be tied to health cost growth benchmark, if applicable.

How is it enforced?

To enforce providers' compliance with the out-of-network rate limit, the model would:

(a) Make a violation an unfair trade practice enforceable by the relevant agency (e.g., the health agency or commission), state Attorney General, and affected individual;

(b) Require the provider to refund the health plan and pay a penalty payment to the affected individual; and

(c) Provide authority for the enforcing state agency or agencies to audit providers and payers to support enforcement.

Q&A on Out-of-Network Rate Limits*

- What is the goal of the policy? What problem does it address?
- Why does the model set the limit as the lesser of median in-network or a percentage of Medicare? Could a state pick just one?
- How will a state determine the multiplier of Medicare, [X]%?
- How is this different than surprise billing laws?
- How do we ensure savings will be passed on to consumers?
- Could this negatively affect consumer access?
- Should a state be concerned about ERISA preemption?
- How does this model law affect health equity?

*Q&A resource on these questions available at: nashp.org/qa-model-act-to-limit-out-of-network-provider-rates

Medicare Reference Pricing in Oregon's State Employee Health Plans

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Oregon's State Employee Health Plans

pebb
Public Employees' Benefit Board

Provides benefits to employees of 200+ state agencies and universities

oebb

Provides benefits to 240+ school districts, education service districts, community colleges

- Local government jurisdictions and special districts may opt in
- Together OEBB and PEBB cover approximately 300,000 lives
- About 15% of state's commercially insured

Oregon Health Authority

Medicare Reference Price Payment Limit

- Established under Senate Bill 1067 (2017)
- Applies to inpatient and outpatient hospital services and supplies at 24 of the state's 62 hospitals (applies to larger/DRG hospitals, smaller/rural hospitals exempt)
- Health plans and ASOs that contract with state employee health plans may not pay more than 200% of Medicare rates at network hospitals; 185% of Medicare rates at out-of-network hospitals
- Hospitals paid under these limits may not balance bill
- Took effect late 2019 (OEBB) and early 2020 (PEBB)

Impact

- Savings recognized in first two years
  - 2020: $59 million, about 14% of facility claims subject to the limit
  - 2021: $112 million, about 33% of facility claims subject to the limit

- Higher savings recognized in second year for several reasons
  - Initial implementation resulted in higher payments in some instances, particularly for inpatient. Rules subsequently clarified payments were to be made at the lesser of billed charges, contracted rates, or the payment limit
  - Gradual return to typical utilization levels after suppressed utilization in 2020-2021 due to Covid pandemic

Impact

- Savings concentrated in outpatient services, which at baseline were at a higher percentage of Medicare rates as compared to inpatient
    - Outpatient ~ 250% Medicare prior to the payment limit
    - Inpatient ~175% Medicare prior to the payment limit

- Compared to Oregon market benchmark data
    - Payments were about 5% higher than benchmark prior to the payment limit (average reimbursement was ~215% of Medicare)
    - 2021 average reimbursement is about 20% lower than benchmark (~160% Medicare)

Considerations

- Medicare rates are a useful and broadly familiar price benchmark, but may not be the most appropriate price benchmark for certain types of services (for example - maternity, neonates)
- Defined payment limits may influence some providers to seek increases beyond current payment levels for certain services
- Payment limits may influence provider perspectives on advancing Value-Based Payments (VBP) and transition away from fee for service
- Unclear how payment limits applied to a subset of the commercial market may impact the broader market

Questions?

Thank you!

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