

# Reimbursement Reform

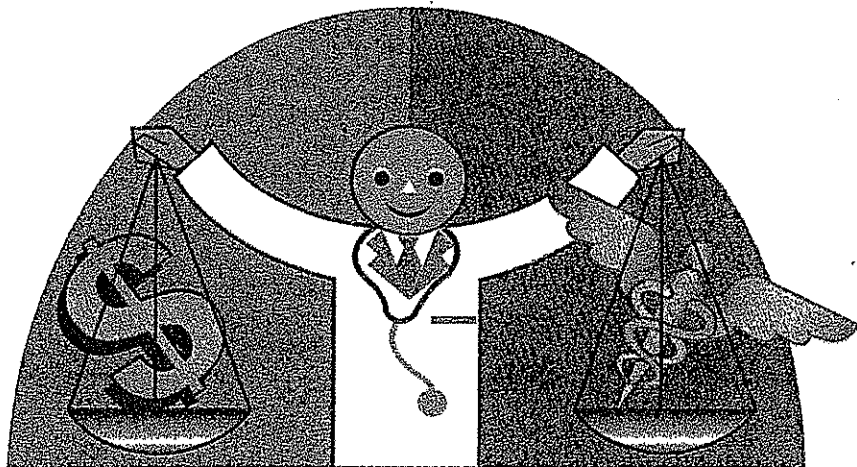
Small board contemplates big changes for out of network providers

By Bruce H. Nagel, Grace D. Mack and Divya Srivastav-Seth

Insurance carriers and other third-party payers of health care benefits have long been at odds with out of network providers and facilities. Payers would prefer for all health care providers to become part of a contractual network which would allow for negotiated fees and other cost savings mea-

challenged reimbursement decisions based on UCR determinations on ERISA and state common law grounds but have been stymied by payers' refusal to disclose data or methodology used to calculate reimbursements and the courts' unwillingness to articulate a specific standard.

However, the State of New Jersey has established a specific regulatory standard, which must



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asures. Out of network providers want to maintain independence in medical decisions and not reduce revenue. The patient beneficiary is forced to choose between lower premiums for standardized health care and higher premiums for specialized health care.

Out of network benefits are routinely calculated on the basis of usual, customary and reasonable determinations. Generally, reasonable and customary refers to the usual charge of other doctors or providers of similar training in the same or similar geographic area. Patients and providers have both

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be adhered to for the calculation of benefits based on reasonable and customary amounts with respect to small employer group health benefits. This regulatory provision, N.J.A.C. 11:21-7.13, entitled "Paying Benefits," requires the use of the 80th percentile of a defined, updated database for medical services and for the use of actual charges for hospital services. The regulation was adopted by the Small Employer Health Benefits Program Board (SEHBP Board) pursuant to a comprehensive statutory reform of the small employer group health market. See Small Employer Group Health Benefits Act, N.J.S.A. 17:27A-17 et seq. This regulation has been invoked in two lawsuits currently pending in federal and state court to require restitution of reimbursement bene-

fits.

The SEHBP Board, the state agency charged with drafting and enforcing regulations relating to small employer health plan benefit determinations, is contemplating redrafting this standard and calculating payment of benefit determinations on a different standard, including Medicare-based methodology.

## Legal Background

Two recent lawsuits, which challenge UCR determinations by insurance carriers, invoke N.J.A.C. 11:21-7.13 "Paying Benefits" as grounds for reimbursement. In *Wachtel v. Health Net*, 2004 U.S. Dist. Lexis/6034 (District Court, 2004) and *Wayne Surgical Center v. Horizon Blue Cross Blue Shield* (Docket No. ESX-L-2951-05, Superior Court, New Jersey), plaintiffs assert either deliberate or negligent underpayment of health benefit determinations under the regulation. N.J.A.C. 11:21-7.13 specifically provides:

(a) In paying benefits for covered services under the terms of the SEHB plans provided by health care providers not subject to capitated or negotiated fee arrangements, small employer carriers shall pay covered charges for medical services on a reasonable and customary basis or actual charges, and for hospital services, based on actual charges. Reasonable and customary means a standard based on the Prevailing Healthcare Charges System for New Jersey...incorporated herein by reference published and available from Ingenix, Inc.

1. The maximum allowable charge shall be based on the 80th percentile of the profile.

2. Carriers shall use the profile effective as of July 1993, and shall update their

databases within 60 days after receipt of periodic updates released by the Prevailing Healthcare Charges Systems.

This regulation, in its earlier incarnation, referred to the Prevailing Healthcare Charges System database published by HIAA, the Health Insurance Association of America. It was later amended to reflect the change of ownership of the database from HIAA to Ingenix, Inc., which is an affiliate of United Healthcare.

In the *Wachtel* case, plaintiffs asserted inter alia that Health Net had failed to rely on the most recent, up-to-date data required under the regulation. In the *Wayne Surgical Center* matter, plaintiffs asserted that UCR calculations were either deliberately or negligently calculated in violation of the statute's clear directive either to use actual charges for a basis of reimbursement of hospital services or the 80th percentile of the current Ingenix database for medical services.

In the Health Net case, interim dispositions involving the New Jersey Department of Banking and Insurance have resulted in some measure of restitution based in part upon the dictates of the regulation.

#### Legislative History

N.J.A.C. 11:21-7.13 was part of the New Jersey State Legislature's comprehensive overhaul of the individual and small employer group health markets (2-50 employees) to provide universal coverage for people in these markets. The key components of the Small Employer Group Health Benefit Act (N.J.S.A. 17:27A-17 et seq.) were to increase accessibility and affordability through the standardization of plans offered in this market.

The SEHBP Board was established to draft and enforce regulations relating to the law. The SEHBP Board was specifically charged with establishing benefit

levels, deductibles and co-payments, which are applicable to participating and nonparticipating providers. N.J.S.A. 17B:27A-33.

The SEHBP Board was required by statute to include 10 elected members and six appointed members representing insurance carriers, health maintenance organizations, relevant government agencies, physicians, organized labor and the public at large. N.J.S.A. 17B:27A-29. The physician position, as well as the public at large positions (one of which has recently been filled), have been vacant for a significant number of years.

Under N.J.S.A. Section 17B:27A-33, every small employer health benefits carrier, as a condition of conducting business in the state, is required to offer five standardized plans formatted by the SEHBP Board.

These plans require any determination of "reasonable and customary" within the context of any nonnegotiated or out of network coverage to adhere to whichever standard the SEHBP Board authorizes. Accordingly, any provisions in traditional indemnity plans, PPO and POS plans would have a uniform definition of reasonable and customary in the small employer group health market. N.J.A.C. 11:21-7.13 provides this uniformity and standardization for reimbursement of benefits for out of network providers in the small employer group health market and is incorporated by reference in each of the five standardized plans.

This regulation is unique to New Jersey. It is significant in its specific requirement for usage of a

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certain percentile and database as well as its demarcation of the grounds for medical services and hospital services reimbursements. While an identical provision exists within the context of the Individual Health Insurance Reform Act, New Jersey does not specify any standard for calculation of UCR amounts in the large employee group (50-plus employees).

The SEHBP Board is currently reviewing the regulation a decade after it initially drafted and adopted it and is contemplating using a Medicare-based methodology reimbursement scheme as its replacement.

## Medicare-Based Methodology Implications

It is generally accepted that the use of Medicare-based reimbursement methodology will significantly increase the cost savings

units, not dollars, as its measurement. Every year as part of its budget responsibility, Congress employs a conversion factor by which to multiply against these units to determine the government's fiscal responsibility to its Medicare population. Accordingly, while RBRVS is a largely accepted measure for reimbursement methodology, it is the conversion factor which determines the actual dollar amount paid to the patient or to the provider.

Typically, physicians do not advocate for the application of Medicare-based reimbursement methodology in the private sector because of the possibility that it would serve as a cost containment tool for the insurance companies who could use any conversion factor they wished at the expense of patients and providers in an era of ever increasing cost for health care and medical malpractice coverage. (AMA Policy Bulletin D-400.990)

In addition, RBRVS was designed and implemented as a

adult, the relative value will be valued according to the work required to provide the service to adults, and will not reflect possible additional work required to provide the service to a child.

## Effect on Patient

It is important to note that, technically, a regulatory change to a Medicare-based methodology will not alter physician costs or charges for services rendered, but will substantially reduce carrier reimbursement to patients for these charges. If the physician is not reimbursed for his entire charge, he is forced to seek reimbursement directly from his patients. Traditionally, physicians either collect their fees up front from patients, in which case the patients submit their own claims for reimbursement, or patients assign their benefits for direct payment to the provider, in which case the physician will still bill the patient for any excess amounts due. The practice of billing the patient for the amount unpaid by its carrier is "balance billing." In any event, the patient still bears the burden of the increase in payment due to the decrease in reimbursement caused by calculating payment of benefits on Medicare-based methodology.

It is apparent that Medicare-based reimbursement methodology is not any more standard, uniform or consistent in its payments determinations than the current system. Its implementation would not necessarily improve the current situation, but rather cause it to deteriorate further by increasing patient payment responsibilities thereby incurring the very risks that the state legislature sought to avoid.

The Small Employer Health Benefits Program Board has a significant impact on the livelihood of physicians and the quality of health care for patients. It is now incumbent upon providers, physician groups and patient advocacy groups alike to become educated and involved in its current and proposed actions. ■

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of the insurance carrier by reducing payment of benefits for the patient and the provider.

In the early 1990s, in an effort to contain governmental cost for the program, Congress changed Medicare reimbursement methodology from a charge-based system involving usual, customary and reasonable factors to a resource-based analysis or resource-based relative value scale (RBRVS). This relative value scale utilizes work

means for the government to contain its own reimbursement costs with respect to its Medicare beneficiaries, the vast majority of whom are over the age of 65. The RBRVS parameters reflect services provided to a "typical" patient, and some specialties do not treat "typical" patients and may receive payments that are not representative. For example, when the service can be provided to both children and adults, but the typical patient is an