Proposed Legislation Seeks to Place Further Strain on Out-of-Network Providers

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Freedom of choice has always been a tenet of society in the United States. However, health care providers’ choices regarding whether to participate in an insurance network or remain out of network are becoming more and more constrained. Over the past few years, case law and legislative developments in New Jersey have restricted the out of network insurance market, making it difficult for providers to stay out of network. The latest piece of proposed legislation, Assemblyman Gary Schaer’s out-of-network bill (A3378) introduced in October, and amended in early November, places even tighter restraints on providers and facilities that choose to remain out of network.

Insurance carriers already have numerous tools to disincentivize patients from treating with out-of-network providers. Carriers charge higher prices for out of network products and services by implementing higher deductibles and copayments. Also, if out-of-network products become too expensive, employers start to purchase less costly managed care plans for their employees. If fewer elect to purchase out-of-network plans, then out of network providers will have fewer patients which will cause the providers to reduce their fees or elect to go in-network. By placing substantive restrictions on the out-of-network market, the insurance carriers are frustrating the healthy competition that exists for physician reimbursement rates. By forcing providers to go in-network, providers will lose the ability to negotiate competitive rates with insurance carriers.

Assemblyman Schaer’s bill restricts out-of-network providers with regard to waiver of copayments co-insurance, or any other financial obligation the patient has to the out-of-network provider. The bill proposes to prohibit out-of-network providers from waiving payments from patients in “any manner or form which a reasonable person would recognize as an inducement to obtain services or supplies from the physician or health care facility.” Further, waiver of a payment as part of an advertisement would be an automatic violation of the proposed law. The proposed legislation provides for an exception to the rule if the provider determines that a patient has a medical or financial hardship. In that case, providers may waive the patient responsibility so long as such waivers are not “routinely or excessively” granted and the insurance carrier is notified of the waiver. However, the law fails to define “routinely or excessively;” meaning it is unclear whether five, ten, or twenty waivers could satisfy a routine or excessive waiver and subject the provider to punishment.

The proposed statute appears to contradict previously decided cases on this issue, specifically Feiler v. New Jersey Dental Association, 191 N.J.Super. 426 (App. Div. 1983) and Garcia v. HealthNet of New Jersey, Inc., 2009 WL 3849685 (App. Div. 2009). In both cases, the medical providers would not collect co-payments or co-insurance from their patients, and, instead accept as payment in full the amount paid by the insurance carrier. In Feiler, the court explained that the provider was not prohibited from routinely waiving co-payments, but was required to specifically inform insurers of his intent to waive them. In Garcia, the out-of-network provider did not have the intent to waive co-insurance at the time the patient was seen. Instead, the provider was unable to collect the co-insurance amounts owed. As a result, the court found that the provider did not act unlawfully by failing to collect co-insurance because the provider did not have a legal or contractual obligation to collect it. Oftentimes, out-of-network providers do not know what a patient’s financial responsibility is because carriers do not disclose this information. In fact, some carriers have corporate policies that prohibit taking calls from out-of-network providers. Therefore, while a provider may have the intent to collect payment in full from the patient, it may not be able to do so in practice, and failure to collect may lead to penalties under the proposed law.

Moreover, it is unfair to place the burden on providers to collect a patient’s financial responsibility for services provided. Providers do not know for certain the exact amount of a patient’s responsibility for a particular visit or procedure. On the other hand, insurance carriers have access to this information because the carriers write the plans and set the fees. Insurance carriers have the money, resources, staff and technology to make the effort to collect from patients. However, it’s much easier for the carriers to make the providers out to be the “bad guy” and put the onus on the providers to collect, even if the providers do not have the same capabilities as the insurers to do so.

The proposed legislation would also require out-of-network facilities and physicians providing non-emergency or elective services to discuss the following with the patient in easily understood terms: (1) a description of the procedure to be performed; (2) an estimate of the costs; and (3) provide notice the patient to contact his or insurance company for further consultation regarding the costs of the procedure. With regard to all types of procedures, physicians and facilities would be required to inform patients whether the health care services they seek are in network or out of network and what the patient’s financial responsibility is towards the service, all of which must be discussed at the time the patient schedules the appointment. These proposed pre-treatment disclosures are unduly burdensome on providers. Again, providers do not know what the patient’s financial responsibility is and the proposed rule implies that providers will have a duty to determine what that responsibility is. This could prove to be difficult if there is no open communication between insurers and out-of-network providers. The provider’s sole responsibility with regard to these pre-treatment disclosures should be to advise the patient that he or she will have some financial responsibility and then to tell the patient to contact his or her insurer regarding the details of that responsibility. The insurance companies should bear the burden of providing patients with this information because insurers have this information at their fingertips.

Another important provision of the bill involves facility-based providers (e.g. specialists such as radiologists, anesthesiologists, cardiologists, etc.). If a patient receives treatment from a facility-based provider at an in-network facility, the facility will need to provide the patient with treatment services at a rate equal to the average in-network treatment rate for the patient’s treatment as determined by the State Department of Banking and Insurance (“DOBI”). If the facility is out-of-network, the facility-based provider will need to ensure
the patient that the charge for services will be the same as the in-network rate. This provision essentially gives DOBI the power to set fees for facility-based providers at the average in-network rate, which eliminates any ability of the facility-based providers to negotiate their rate contracts. This new law also places a burden on facilities to subsidize specialists for the services provided since they are required to be on-site under relevant facility licensure regulations. Ultimately, this new law has the potential to force hospital-based providers to be in-network.

With the introduction of this legislation, the struggle continues for out-of-network physicians and facilities. Although Assemblyman Schaer’s bill has yet to make it out of committee, the insurance industry continues to fight to see this legislation passed. The same bill was also recently introduced in the Senate. Out-of-network providers should closely monitor the status of these bills because it is clear that, if passed, their choice to remain out-of-network may be completely eliminated in the near future. If more providers are forced to go in-network, these bills will impact existing in-network providers. An overall increase in in-network providers will stifle competition for in-network reimbursement rates. As a result, in-network providers are encouraged to monitor the bill as well.

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