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Out-of-Network Does Not Have To Mean Out of Options for N.J. Hospitals

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One of the difficult decisions facing hospitals is whether to be "in-network" or "out-of-network." In-network hospitals have contracts with commercial insurers to accept discounted rates. In-network hospitals tend to have fewer denied claims and more timely payments from insurers. However, many hospitals find these advantages are outweighed by one huge disadvantage — extremely low in-network reimbursement rates. Low insurance reimbursement rates have been blamed for a wave of hospital closures and bankruptcy filings in New Jersey. This problem has driven a number of New Jersey hospitals to explore leaving insurance networks altogether and becoming out-of-network with respect to some or all of the state's large commercial insurers.

Out-of-network status provides hospitals with the ability to charge for their services and products as they see fit, free from contractual restraints with insurers. On a per-claim basis, reimbursement rates tend to be higher than in-network reimbursement rates. And, once a hospital has left an insurance network, it may be able to use its out-of-network status as a basis to negotiate higher in-network rates with insurers. With out-of-network status, however, comes the risk of substantially reduced volume as the result of the loss of referrals from insurers, more scrutiny from insurance carriers and more denied claims. How to respond to these risks and maximize the advantages of being an out-of-network provider requires careful preparation and an understanding of the legal issues involved.

The starting point in deciding whether to leave an insurance network is a careful review of the hospital's network agreements with commercial insurers. Typically, network agreements will specify that they are effective for a period of years, and many will also automatically renew if the provider does not give notice within a specified time period — often as long as six months or more. Failure to provide timely notice in the form specified by the network agreement may significantly delay the hospital's ability to leave an insurer's participating provider network.

Under current law, New Jersey hospitals operate under a deregulated rate-setting system and are free to set charges for products and services as they see fit. However, insurers will be more likely to scrutinize claims for services based on charges significantly in excess of in-network rates. Thus, an out-of-network hospital submitting claims based on full charges should make sure that it will be able to defend its charges if challenged by insurance carriers.

An out-of-network hospital no longer has a direct contractual right to reimbursement from an insurance carrier. To acquire the right to reimbursement, its patients must assign to the hospital their rights to receive benefits under the applicable insurance plans and policies. Typically, hospitals can obtain such assignments by requiring their patients to execute assignment-of-benefits forms upon admission to the hospital. However, courts have insisted that the assignment of benefits forms be broad enough to encompass the patients' rights to receive the benefits of their health plans' out-of-network coverage. Thus, an out-of-network hospital should carefully scrutinize its assignment-of-benefit forms with counsel to ensure that the forms are broad enough to survive anticipated challenges from insurers.

Once the hospital makes the decision

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to leave an insurance network, some insurers may become hostile by engaging in conduct intended to frustrate the hospital's out-of-network objectives. The hostility can vary in each instance. Insurers may issue public statements about the hospital's decision to go out-of-network, via media advertisements and letters to the insurer's members and participating physician groups. These statements will likely portray the hospital and its decision in a negative light, in an attempt to discourage patients from continuing to use the hospital for out-of-network medical services. Hospitals should anticipate such negative publicity and be prepared to counter it with publicity of its own explaining the circumstance surrounding the decision to go out-of-network, its out-of-network billing policy and the implications of this policy for future patients.

A hospital should also anticipate that insurers may implement practices intended to counter the increase in emergency care reimbursements that carriers are obligated to pay nonparticipating providers under New Jersey law. For example, an insurer may implement draconian utilization management procedures intended to eliminate all, or significant portions of, otherwise appropriate out-of-network claims. An insurer may also create reimbursement methodologies that fix reimbursement at an artificially low percentage of out-of-network charges regardless of the nature and amount of the charge. Out-of-network hospitals must be vigilant in monitoring insurers' conduct after termination of their commercial insurance agreements. If any improper denial or underpayment patterns are discovered, then the provider may need to act immediately with claims appeals, arbitrations and, if necessary, litigation.

Fortunately, the decision to go out-of-network does not mean that commercial insurers can act arbitrarily in deciding when and how much to reimburse out-of-network hospitals. As interpreted by the Department of Banking and Insurance, New Jersey's HMO regulations require that, when a patient seeks emergency treatment at an out-of-network facility, the insurer must pay the out-of-network provider a benefit large enough to insure that the provider does not balance-bill the patient for the difference between its billed charges and the insurance payment. This is so even if it means that the insurance company must pay the provider's billed charges less the patient's in-network co-payment, co-insurance or deductible. See *In the Matter of Violations of the Laws of N.J. by Aetna Health Inc.*, DOBI Order No. A07-59 (July 23, 2007). These and other statutory and regulatory provisions require that, when a commercially-insured patient seeks emergency treatment at an out-of-network hospital, in New Jersey, the patient's insurer must reimburse the out-of-network hospital for all or a substantial portion of the hospital's billed charges. Moreover, since 2011, New Jersey health insurers that provide in-network and out-of-network benefits must reimburse out-of-network providers directly, or send a check payable to both the provider and the patient as joint payees, if the covered plan member signs an assignment of benefits form for medically necessary health care services. N.J.S.A. 26:2S-6.1(c). This statute ends the practice previously employed by some health insurers in New Jersey of sending reimbursement for treatment provided by an out-of-network facility directly to the patients, forcing hospitals to expend considerable resources in pursuing patients directly for the reimbursements.

Once out-of-network, many health-care providers may wonder whether they can lawfully waive patients' co-payments, co-insurance and deductibles. Out-of-network hospitals may find it desirable to waive such payments to avoid involving patients in disputes with insurers and to encourage patients to continue seeking treatment at the hospitals without the fear of large balance bills. However, this practice presents a number of challenges. The U.S. Department of Health and Human Services has taken the position that a provider's routine waiver of such payments in the Medicare and Medicaid context may violate the Anti-Kickback Act or the Medicare False Claims Act. Several states, including New York, prohibit the practice with respect to commercial payers. However, while there have been recent efforts in the New Jersey legislature to outlaw the practice, there is currently no law, regulation or judicial decision that prohibits an out-of-network hospital in New Jersey from waiving co-payments, co-insurance payments and deductibles for commercially insured patients.

Commercial insurers in New Jersey nonetheless vigorously oppose the practice, and some have instituted lawsuits alleging that such waivers result in the submission of fraudulent insurance claims in violation of the New Jersey's Insurance Fraud Prevention Act (IFPA), N.J.S.A. 17:33A-1 et seq., and under common law. Some such suits have survived the pleading stage. However, recently, Bayonne Medical Center (BMC), an out-of-network hospital, was able to successfully defeat two such lawsuits at the summary judgment stage. After becoming an out-of-network provider in 2008, BMC publicly announced a billing policy under which it would not collect co-payments, co-insurance and deductibles from commercially insured patients once it received what commercial insurers were legally required to reimburse the hospital. Although BMC later changed this waiver policy, both Horizon Blue Cross Blue Shield of New Jersey and Aetna Health Inc. filed separate lawsuits against BMC, alleging that the practice violated the IFPA and constituted common-law fraud. *Horizon Blue Cross Blue Shield of N.J. v. IJKG*, No. ESX-C-125-09; *Aetna Health Inc. v. DKG Opco,* No. ESX-L-7678-11.

On Aug. 12, 2011, the court granted BMC's motion for summary judgment as to Horizon's lawsuit, finding, among other things, that BMC's full disclosure of BMC's published billing policy, and Horizon's awareness of that policy, prevented Horizon from claiming a violation of the IFPA or common-law fraud as a matter of law. Then, on Feb. 17, the court granted BMC's motion for summary judgment as to Aetna's lawsuit, similarly finding no basis for Aetna's claim that BMC's published waiver policy constituted an IFPA violation or common-law fraud. BMC's successful defense of Horizon's and Aetna's lawsuits demonstrates that it is possible for out-of-network hospitals in New Jersey to develop waiver policies for commercially insured patients that will survive judicial scrutiny.

The decision to go out-of-network is never easy for any New Jersey hospital, and the anticipated resistance from the insurance industry makes the decision all the more difficult. Fortunately, however, with careful preparation and an understanding of what to expect, New Jersey hospitals can navigate the transition to out-of-network status successfully. ■