

AETNA PENALIZED \$9.5 MILLION AND ORDERED TO PAY REPARATIONS TO OUT-OF-NETWORK PROVIDERS

This week the New Jersey Department of Banking & Insurance (DOBI) fined Aetna almost \$9.5 million for its attempt to pay certain out-of-network providers what it deemed a “fair” amount—125% of Medicare—rather than the providers’ billed charges. DOBI also ordered Aetna to directly pay the affected providers’ billed charges, in reparation, for certain services rendered out-of-network. The \$9,457,500 total penalty is among the largest that DOBI has ever levied against a healthcare insurer and includes penalties in the amount of:

- \$650,000 for *misrepresenting its obligations* in letters sent to 130 providers (amounting to \$5,000 per offending letter);
- \$7,747,500 for *not attempting in good faith to effectuate prompt, fair and equitable satisfaction of the claims* for certain services; and
- \$530,000 for *not providing its HMO member/patients the right to be free of balance billing by providers for medically necessary services* that were authorized or covered.

Aetna’s recent payment policy was apparently directed toward providers who rendered services to Aetna’s HMO patients for emergency care, for services rendered by non-participating providers during an admission to a network hospital by a network provider, and for services rendered by non-participating providers pursuant to a referral or authorization by Aetna. Aetna took the position in letters to the out-of-network providers that it was only obligated to pay its determination of a “fair” amount, which it deemed to be 125% of the Medicare allowable amount. Aetna further stated that no additional payment would be considered. Physicians objected to this new payment practice and took the matter to DOBI.

In its order DOBI cited New Jersey regulations requiring Aetna’s HMO to limit their member/patients’ liability for services to the network co-payment, deductible or coinsurance when rendered during emergency care and during an admission to a network hospital by a network physician. DOBI also cited regulatory authority for the proposition that an HMO is fully responsible for payment when it refers a patient to a non-participating provider.

Reading the regulations together, DOBI found that member/patients “have no liability for the difference between the non-participating provider’s billed charges and the benefit paid by the HMO because the member is responsible only for the network copayment, coinsurance or deductible.” DOBI further found that “Aetna must pay the non-participating provider a benefit large enough to insure that the non-participating provider does not balance bill the member for the difference between his billed charges and the Aetna payment, even if it means that Aetna must pay the provider’s billed charges less the member’s network copayment, coinsurance or deductible.”

Aetna has 30 days to object to DOBI’s order.

MSNJ applauds DOBI for enforcing the regulations that require adequate reimbursement to out-of-network providers and that protect HMO patients from paying a larger than bargained for share, out-of-pocket, for their medically necessary expenses. MSNJ recognizes the leadership of physicians who took Aetna to task and provided DOBI with the information needed to pursue this important enforcement action. MSNJ encourages our members to continue the battle against insurers for truly fair and adequate reimbursement rates to ensure patient access to quality care in New Jersey.