

Mitigating Surprise Medical Bills

Background: Issues surrounding beneficiaries being burdened with high out-of-pocket costs and inadequate provider networks present real issues for patients in need of life saving diagnostic imaging services. Patients, physicians, and policymakers are also deeply concerned about the negative impact of unanticipated medical bills on the patient-physician relationship and the healthcare system overall. In reality, it is more accurate to associate “surprise medical bills” with insurers capitalizing upon consumers’ desire for low-cost insurance premiums rather than labeling physicians as “greedy” predators who knowingly take advantage of their patients.

Too often, health plans fail to disclose potentially costly flaws in their plans, including greater responsibility for out-of-pocket costs and the financially burdensome impact of inadequate provider networks. As a result, patients who only look at the monthly cost of health insurance premiums as a measure of how comprehensive their health plans are, usually find out after they have either been diagnosed with a serious ailment or suffered major trauma, that the specialty physicians needed to render medically necessary care are not within their inadequate network of providers.

Issue: Health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, pharmacies, and other providers as a key mechanism for controlling cost. As a result, even patients who are diligent about seeking care from in-network physicians and hospitals may face unanticipated out-of-network bills from providers who are not in their insurance plan’s network, simply because they were unaware of the full breadth of providers involved in their care. Physicians and other providers are limited in their ability to help patients avoid these unanticipated costs because they, too, may not know in advance who will be involved in an episode of care, let alone other providers’ contract status with all the insurance plans in their communities.

The problem of unanticipated out-of-network bills is complex, and requires a balanced approach to resolve. In addition to providing strong patient protections, the ACR believes the following recommendations would improve transparency, promote access to appropriate medical care, and avoid creating disincentives for insurers and health care providers to negotiate network participation contracts in good faith.

Congressional Recommendations (House and Senate): As Congress works to develop a comprehensive solution to mitigate the issue of unexpected medical bills, the ACR urges lawmakers to address the following:

- **Protections for Patients.** Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills. In addition, physicians should be provided with direct payment/assignment of benefits from the insurer to ensure patients are not mired by payment rate negotiations between insurers and providers. *Patients who choose in advance* to obtain scheduled care from out-of-network physicians, hospitals or other providers should be informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

- **Insurer Accountability.** Health insurance plans often rely on narrow, inadequate networks of contracted physicians, hospitals, and other providers. Insurance plans have chosen to offer these products with narrow, inadequate networks as a mechanism for managing costs. These products are many times deficient in key health care providers. Robust network adequacy standards include, but are not limited to, an adequate ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition. To ensure the aforementioned standards are upheld, strong oversight and enforcement of network adequacy is needed from both the federal and state governments.
- **Impact of Benchmarking Payments.** The establishment of caps or benchmarked payments for physicians treating out-of-network patients is not a viable solution. Instead, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. Medicare rates are inadequate for this purpose because they establish artificial rates based on budgetary constraints and policy agendas rather than market forces. Nor should rates be based on negotiated in-network rates, which would have the effect of eliminating the need for insurers to engage in meaningful negotiations.
- **Modeling of State Solutions.** Several states have implemented out-of-network billings laws that present tangible templates for a federal solution. Of these states, the New York law strikes a careful balance among key health care stakeholders, including physicians, hospitals, and health insurers, and has had success in protecting patients from large unanticipated medical bills. The law includes comprehensive patient protections, holds insurers accountable for maintaining adequate networks of physicians and specialists, establishes reasonable patient benchmarks and an effective alternative dispute resolution (ADR) for those circumstances where the payment offered is disputed due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other impacting factors. In addition, ADR must apply to state and ERISA plans and Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.
- **Applicability for all Plan Types.** Overall, any federal legislative solution to address unexpected out-of-network medical bills should apply to all plan types, including ERISA.