

ACP Talking Points Surprise Medical Bills

July 1, 2019

Unanticipated, or surprise, medical bills can arise when patients reasonably believe the care they received would be covered by their health insurer but it was not. Such situations may include:

- ✓ When a patient receives care in an emergency from physicians or facilities who have not been contracted by their health insurance company; or
 - ✓ When a patient receives scheduled care from an in-network physician at an in-network facility but other participants in the episode of care, whom the patient did not have an opportunity to choose, are not in their insurer's network.
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- In these cases, patients should be responsible only for the cost-sharing amounts they would otherwise have been subject to if the care had been provided in-network and these costs should count toward their in-network out-of-pocket maximums and annual deductibles.
 - Several legislative proposals in Congress would mandate that in cases where patients receive out-of-network services in an emergency or from out-of-network physicians at an in-network facility, the plan would only be required to pay the physician at the plan-specific median in-network rate.
 - By establishing this government mandated payment benchmark, plans have strong incentives to eliminate providers with contracts above that amount or to reduce the rates in those contracts.
 - Median in-network rates do not fairly reflect the cost of providing services by all "providers" nor do they capture other benefits that go hand-in-hand with being in-network, such as additional incentive payments as part of value-based contracts, prompt and direct payment by plans, listing in provider directories, etc.
 - It is critical therefore that there be a fair and balanced mechanism for arriving at the appropriate rate for those physicians who do not have a contract with a given insurer. At no point should negotiated, discounted in-network rates be used as a benchmark to determine fair payment to out-of-network physicians, and at every point commercial data from independent sources should inform the payment standard.
 - When the minimum payment from the payer for out-of-network care is insufficient, an independent dispute resolution (IDR) process should be developed to determine a fair payment by the health insurance company for the care provided. The IDR should be structured with clear factors that an arbiter, familiar with health care billing, must consider when deciding such as the complexity of the case, the experience of the physician, and the rate that physicians charge for that service in the area.
 - As lawmakers continue their work in a bipartisan fashion to address this issue of surprise billing, it is critical that any final legislation hold patients harmless from surprise medical bills, that lawmakers reject inclusion of a specific median in-network rate and instead adopt an independent dispute resolution process to determine fair payment for services in these settings.