Surprise billing: 7 principles to fix a broken system

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Overly narrow and inadequate provider networks are resulting in cost-shifting from insurance companies to patients who are being charged with unanticipated medical bills.

Insurers have been calling this situation “surprise billing,” and Congress is exploring what can be done to protect patients. The AMA has offered guidance into doing so.

The AMA joined with more than 100 specialty and state medical societies and other health care organizations in a letter to leaders of the Senate and House committees of jurisdiction expressing their concerns on this issue.

“Health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, pharmacies, and other providers as one mechanism for controlling costs,” the letter states.

Even patients who research which physicians and hospitals are in their insurance network may receive unanticipated out-of-network bills “because they had no way of knowing and researching in advance all the individuals who are ultimately involved in their care,” the letter adds.

The AMA and the other organizations detail seven principles for Congress to consider when developing legislation that seeks to protect patients from costs their insurance will not cover.

Insurer accountability. Strong oversight and enforcement of network adequacy is needed from both federal and state governments. This includes 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.

Other aspects of insurer accountability include having accurate provider directories. The groups also said patients should be protected from unexpected emergency-care bills in instances where they were unable to accurately self-diagnose if the worrisome symptoms they had were due to an emergency

medical condition or not.

Limits on patient responsibility. Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills.

Transparency. Patients who choose to obtain scheduled care from out-of-network providers should be told by those providers prior to receiving care about anticipated charges. Insurers should tell how much they will cover.

Universality. Legislation to address unanticipated out-of-network bills should apply to plans governed by the Employee Retirement Income Security Act of 1974.

Set benchmark payments. Legislative caps on payment for physicians treating out-of-network patients should be avoided. But, if pursued, payment guidelines or limits should reflect actual charge data for the same service in the same geographic area. They should not be based on Medicare rates, which have become increasingly inadequate in covering overhead costs.

Dispute resolution. There should be a dispute-resolution process for circumstances where the minimum payment standard is insufficient due to the complexity of the patient's medical condition.

Don't put patients in the middle. Patients should not be burdened with negotiations. Physicians should be given direct payment or assignment of benefits from the insurer.

This balanced approach protects patients, improves transparency, promotes access to appropriate care, and "avoids disincentives" to negotiating network participation contracts in good faith, the organizations told committee leaders.