Whereas, The Affordable Care Act (ACA) provided that if a patient had an emergency hospital admission and was treated by an out of network physician, that the insurer could hold the patient responsible for no more than they would have for an in-network doctor, which seemed to suggest that the insurer would be paying the physician’s bill; and

Whereas, The subsequent Health and Human Service (HHS) regulation on this provision said that in this case, the insurer need pay only the greater of three sums (1) Medicare; (2) the insurer’s in-network rate; or (3) the insurer’s out-of-network rate; and

Whereas, National medical organizations strongly objected at the time that this would leave the determination of the out of network payment entirely up to the insurer; and

Whereas, Most insurers have subsequently changed their out of network rate to a percentage of Medicare, and are therefore not required to pay more than a very small portion of emergency out of network physician bills, leaving patients to pay the majority of the bills; and

Whereas, The HHS regulation further stipulated that the health insurer’s requirement not to hold the patient responsible for more than a small fixed out of pocket yearly maximum did not apply in this case, again freeing the insurer from paying for the physician’s services; and

Whereas, One of the basic provisions of a health insurance plan should be that major emergency bills are covered; and

Whereas, For many physicians, the ability to get paid for emergency work is an important component of their ability to maintain a viable practice; and

Whereas, A new HHS administration might well be willing to reverse a flawed regulation of a prior administration; therefore be it

RESOLVED, That our American Medical Association pursue legislation or regulation to require health plans not regulated by their states (such as ERISA plans) to pay physicians for emergency out of network care at least at the 80th percentile of charges for that particular geo-zip, as reported by the Fair Health database. (Directive to Take Action)

Fiscal Note: Not yet determined

Received: 04/25/18
RELEVANT AMA POLICY

Out-of-Network Care D-285.962
Our AMA will develop model state legislation addressing the coverage of and payment for unanticipated out-of-network care.
Res. 108, A-17

Out-of-Network Care H-285.904
Our AMA adopts the following principles related to unanticipated out-of-network care:
1. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.
2. Insurers must meet appropriate network adequacy standards that include adequate patient access to care, including access to hospital-based physician specialties. State regulators should enforce such standards through active regulation of health insurance company plans.
3. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.
4. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.
5. Patients who are seeking emergency care should be protected under the "prudent layperson" legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.
6. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.
7. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.
8. Mediation should be permitted in those instances where a physicians unique background or skills (e.g. the Gould Criteria) are not accounted for within a minimum coverage standard.
Res. 108, A-17

See also: Network Adecuacy H-285.908