Unanticipated out-of-network ("surprise") medical bills

Patients, physicians and policymakers are deeply concerned about the impact that unanticipated medical bills are having on patient out-of-pocket costs and the patient-physician relationship. 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. As a result, even those patients who are diligent about seeking care from in-network physicians and hospitals may find themselves with unanticipated out-of-network bills from providers who are not in their insurance plan's network—and this can happen simply because they had no way of knowing or researching in advance all the individuals ultimately 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. Given the public's frustration with this situation, both federal and state governments have been exploring options for addressing it.

The American Medical Association strongly supports efforts to protect patients from the financial impact of unanticipated medical bills. While out-of-network physicians are willing to forgo the ability to balance bill patients in these situations for amounts not covered by their patient's insurance company, there must be an impartial mechanism for establishing fair payments to physicians.

Some congressional proposals would mandate that in cases where patients receive out-of-network services in an emergency or from out-of-network physicians they could not choose at an in-network facility, the health 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 would have strong incentives to eliminate providers with contracted rates above that amount or to reduce the rates in those contracts.

Legislation that limits plan obligations to only the median in-network rate also advantages insurers by absolving them of their responsibility to create adequate networks for hospital-based services by protecting them from the consequences of their failure to create those networks. Regardless of their lack of effort to create an adequate network, they could take full advantage of federal limits on the amount they would have to pay for care.

Median in-network rates do not 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 payment by plans, listing in provider directories, etc. Therefore, it is unreasonable to impute that rates for in-network physicians are sufficient or equitable for those who do not enjoy the additional benefits of being in network.

When the minimum payment from the payer for out-of-network care is insufficient, an independent dispute resolution (IDR) process should be available 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, who is 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 geographic area.

A limited IDR process was included in legislation adopted by the House Committee on Energy and Commerce in July, as well as in a joint proposal released in December by the Energy and Commerce Committee and Senate Health, Education, Labor, and Pensions (HELP) Committee. Congress should continue to improve these proposals by requiring the independent third party to consider additional information, such as charge data, when determining the appropriate payment amount.

On Dec. 11, 2019, House Ways and Means Committee Chair Richard Neal (D-MA) and Ranking Member Kevin Brady (R-TX) announced they had reached an agreement on an outline for surprise billing legislation to advance early this year. Details on the agreement are limited, but tentative information that is available indicates that the plan would limit patients' out-of-pocket costs to in-network co-pays and deductibles, and include a yet-to-be defined "robust reconciliation process" to end payment disputes between insurers and providers when they fail to reach a settlement. This process, which could be similar to an IDR system, would not be restricted to claims above a certain threshold amount, nor would it establish a payment benchmark based on in-network payment amounts. Price and network transparency provisions and protections would also be included for patients whose provider networks change during the plan year.

With health extenders only reauthorized until May 22, it is possible that surprise billing legislation could be included in a larger legislative package in May. The AMA and physician community will continue to work with Congress to ensure that any final surprise billing legislation holds patients harmless and includes a fair and balanced approach that treats all stakeholders equally while preserving access to care.

Urge your senators and your representative to support surprise billing legislation that would:

- **Protect patients from out-of-network billing and preserve patient access to hospital-based care by holding insurers accountable for addressing their own contributions to the problem**
- **Establish rates that are fair to all stakeholders in the private market; rates should include actual commercial payer data as determined through an independent claims database**
- **Establish a fair and independent dispute resolution (IDR) process to resolve disputes about payments from insurers to unaffiliated providers for services rendered out-of-network to their enrollees**
- **Require insurers to maintain adequate provider networks to give patients timely access to physicians, including hospital-based emergency physicians and on-call specialists**