Surprise Medical Bills: The Physician Perspective

The medical community remains committed to working with Congress to seek a balanced legislative solution to protect patients from unanticipated (“surprise”) medical bills that can occur when gaps in health insurance coverage lead them to receive care from out-of-network physicians or other providers. As conversations regarding a final compromise solution continue, physicians strongly believe that the following provisions are essential to any surprise medical billing legislative solution to ensure patients’ continued access to quality care:

- **Protecting Patients.** Patients must be protected and should only be responsible for their in-network cost-sharing amounts, including deductibles, when receiving unanticipated medical care.

- **Keeping Patients Out-of-the-Middle.** To keep patients out of the middle of any payment disputes between health plans and providers, provide physicians with direct payment/assignment of benefits from the insurer. Under proposals currently being considered in Congress, patients will continue to receive confusing bills from multiple providers following a hospitalization.

- **Ensuring Reasonable Provider Payment Rates.** Following the delivery of out-of-network medical care, a reasonable payment (as determined by the health plan if a fully accessible independent dispute resolution (IDR) process is available) should be paid directly to providers. A benchmark payment rate based on median or mean in-network contract rates or some percentage of Medicare is unacceptable.

- **Supporting a commercial payer claims database.** An independent and transparent commercial insurance claims database should be established, and must include data from ERISA plans to ensure it is truly reflective of the market.

- **Establishing a Fair, Accessible and Equitable IDR Process.** If the provider determines that the insurer’s payment is not reasonable, there must be a fair, accessible and equitable IDR process to resolve payment disputes. An accessible IDR process must not be restricted to claims above a specific dollar amount/threshold. Nor should providers be limited in accessing the IDR process only after a “cooling off” period. To maximize administrative efficiency, providers should be allowed to “batch” claims for the same or similar service under the same insurance provider. Per the IDR process, both the provider and the health plan would submit their final offer to the arbiter, and in a baseball-style manner, the arbiter would select one or the other offers, without additional negotiation. In determining the appropriate payment rate, the arbiter must consider the following elements:
  - Commercially reasonable rates for comparable services in the same geographic region based on an independent and transparent commercial insurance claims database;
  - Previous contracting history;
  - Demonstration of good-faith efforts (or lack thereof) made by the out-of-network provider or the health plan to enter into network contracts;
  - The market share held by the out-of-network health care provider or the health plan;
  - Level of training, education, and experience, outcomes and quality metrics of the physician providing the service;
  - The complexity of the services rendered;
  - Individual patient characteristics; and
  - Other relevant economic and clinical factors.

- **Safeguarding Patient Access to Care.** Health plans should be held accountable for provider networks that are appropriate to meet patients’ medical needs — including ensuring access to specialists and subspecialists on a timely basis. Health plans must also ensure that that provider directories are up-to-date and accurate. Patients must be allowed to access elective out-of-network care when they so choose.