

Surprise Medical Bills:
*It's time to follow New York's lead and take patients out of the middle
while creating a balanced approach to resolving billing disputes*

Frequently Asked Questions

ISSUE

Patients who unknowingly receive treatment from an out-of-network hospital-based physician should not be financially penalized by an unanticipated gap in their insurance coverage. In those areas where physician anesthesiologists face obstacles to being in a patient's health plan, ASA has supported patient-centered solutions including holding patients harmless, assuring appropriate numbers and types of providers in health plans, and resources so patients know who is in their health plan.

QUESTIONS

→ Why are patients receiving surprise medical bills?

Patients are often learning too late of the deficiencies in their health insurance plans and are surprised with their coverage, deductibles and related responsibilities. In some cases, the patient will receive a bill for the amount remaining between the out-of-network health care provider's fee and the amount contributed by the patient's health insurer after copay and deductible. In other cases, the patient assumes facility-based providers will be covered similarly to their in-network surgeon and hospital, which is not always the case.

→How do we fix this problem?

Using a New York styled approach, surprise bills would disappear. New York's law provides patients, insurance companies, and physicians a predictable course that takes the patient out of the middle and creates a level process for the insurance company and physician to resolve a payment dispute. The law also addresses network adequacy and ensures patients can access or are provided needed information.

→Why are all physicians not in-network?

While there are some physicians who are out of network, most are in-network. Recent data indicates that over 90% of physician anesthesiologists' claims are in-network. Most physicians want the stability and administrative ease that comes with participating in a health plan. However, in some cases, insurance companies are failing to create adequate and readily accessible networks. There are multitudes of reports of insurance companies narrowing networks as a strategy to limit their costs and to shift those costs to patients and other stakeholders. For example, in 2018 the Texas Department of Insurance fined Humana, Texas' fourth largest health insurance writer and ninth largest HMO, \$700,000 for failing to maintain an adequate number of physician anesthesiologists in a number of counties.¹ Contract terminations resulted in an unacceptable decrease in contracted facility-based anesthesiology groups with no in-network facility-based anesthesiologists in dozens of facilities.

¹ Available at <https://www.tdi.texas.gov/news/2018/tdi10082018.html>

→Why not just require the physician to disclose whether they are in-network?

ASA supports the public disclosure requirements that the New York law mandates. As insurance companies have narrowed and tiered their networks, patients and providers alike are often unaware at any given time what plan they are actually considered in-network. Insurance companies have created an elaborate system where a provider may be in-network with one product sold by the insurance company but not another. The insurance companies may also remove a provider without notice from the rolls of its in-network providers. For this reason, insurance companies must be accountable for improving patient access to timely and reliable information.

→What more can you tell me about the New York law?

In 2014, after years of debate the New York legislature approved legislation that resolved the surprise medical billing problem.² The New York law removed the patient from the middle and created a level playing field for physicians and insurance companies to resolve their disagreements. The law applies to emergency services and surprise bills for care in participating facilities by non-participating providers where appropriate disclosures were not provided or where the patient was unable to receive care from a participating provider. It creates a baseball style (i.e. the arbiter picks a winner) independent dispute resolution process which takes into account, among other criteria, the physician's usual charge for comparable services. The law also requires hospitals, physicians and plans to provide clear information about networks and charges. Through the law, usual and customary cost is defined as the 80th percentile of all charges for the particular health care service performed by a provider in the same or similar specialty, provided in the same geographical area, as reported in an independent/non-conflicted benchmarking database.

Since the law went into effect in 2015, negative media coverage of surprise medical bills has essentially stopped. Published reports uniformly demonstrate the success of the law.³ Millions of health care claims are filed each year in New York, yet last year less than 2,000 ended up in the dispute resolution process. Based upon results reported by the state, arbiters' decisions were fairly split between insurers and providers. Importantly, there is no evidence that insurance premium rates increased as a result of this four-year-old law.

→ Could you give me an example of an independent/non-conflicted benchmarking database?

FAIR Health has not only been cited as an example of a database that could be appropriately used; it was established as a result of a settlement stemming from New York State's accusations that the insurance carriers were deliberately manipulating data to their advantage. FAIR Health has no affiliation with any group health plan, health insurance issuer, or provider organization. Approximately 20 states and GAO use the FAIR Health database.

² 2014 Sess. Law News of N.Y. Ch. 60 (S. 6914)

³ Available at https://www.dfs.ny.gov/reports_and_publications/annual_reports/fraud