



Issue: Surprise Out-Of-Network Billing & Network Adequacy

CAP Position: The CAP's goal is to hold patients harmless in these billing disputes, ensure network adequacy and fewer out-of-network services, and if an out-of-network physician provides services to a patient, fairly compensate that physician for the services provided.

Out-of-network bills occur when a patient's insurance plan has not contracted with a physician, hospital, or other provider. Surprise bills occur when a patient must receive out-of-network services at an in-network facility, hospital, or an emergency department setting – and the patient is not aware that the provider is out of his or her network. Typically, this out-of-network cost is partially covered by health insurance and the patient, through no fault of their own, is financially responsible for the remainder of the bill. In recent years, health insurance plans have exacerbated the problem by narrowing insurance networks, thereby shifting more medical costs onto the patient and reducing the financial obligation of the insurance company.

To protect patients from the failure of their health insurance coverage, insurers and providers should settle all payments without the patient's involvement. Further, network adequacy standards for health plans should be imposed to ensure that health plans contract with hospital-based physicians at "in-network" facilities and hospitals. Finally, reimbursement for out-of-network services should be based on data compiled by independent, non-affiliated organizations, such as FAIR Health Inc., or a state all-payer claims database.

Legislative Ask: Support legislative efforts to:

- 1. Hold patients harmless.** Through no fault of their own, patients are caught off guard when an insurer doesn't cover physician services. Patients do not need additional financial stress when they are at their most vulnerable. Accordingly, patients should not be required to pay more for out-of-network physician services at in-network facilities when they cannot access an in-network physician. Congress should create a system whereby insurers and providers can come to agreement independent of the patient, who should only pay for care at an in-network rate. Alternative dispute resolution (ADR) can help address this problem. If there is a payment dispute between an insurer and provider, an independent arbitrator can step in and consider factors pertaining to the case (complexity, duration, etc.) as well as geographically-based charges by providers and payments from insurers to determine the fair market value of the physician service.
- 2. Set network adequacy standards.** Inadequate networks are the root cause of surprise bills. Without adequate networks of contracted physicians, a patient simply cannot be properly guarded from out-of-network health care at an in-network facility. Transparency, while valuable, cannot solve the problem for patients because many physician services are unexpected. Creating and enforcing regulatory standards that require health insurance plans to contract with the requisite number of providers capable of the full array of physician care at an in-network facility is paramount to reducing surprise bills. If there are fewer out-of-network providers to begin with, there will be fewer patients receiving bills. The majority of providers want to be in-network; insurance companies should not be narrowing networks, shifting medical costs to patients, and hiding behind the threat of increased premiums simply to make more money.
- 3. Fair reimbursement for care.** In order to encourage health plans to contract for physician services, and to ensure that the health care delivery system is financially viable, a fair market rate should be paid for physician services. Payment rates to physicians from private payors should not be benchmarked to Medicare. Instead, payments should reflect the market value of the service based on charges and commercial payments for the service for each geographic area where the service is provided. Using independent databases such as FAIR Health Inc, which is the largest repository of private claims data, can help inform any payment formula. This independent database can also help inform arbitrators if an ADR



process is used to settle payment disputes. Importantly, bundled billing or contracting regulation is not an appropriate solution to surprise out-of-network bills. In addition to issues raised by the American Hospital Association, the American Medical Association, and the Federation of American Hospitals¹, requiring physicians to contract with hospitals/facilities for payment for their services leaves physicians with little protection against abusive or exploitive behavior and threatens the independent practice of medicine.

Background:

Health insurance plans are increasingly relying on narrow and often inadequate networks of contracted physicians, hospitals, and other providers to shift medically necessary health care costs onto their enrollees. 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, simply because the patient could not avoid the need and medical necessity for out-of-network physician care.

Physicians and other providers are limited in their ability to help patients avoid these unanticipated costs because they have been denied insurance contracts and/or did not know in advance who will be involved in an episode of care. Moreover, pathologists, like other physician specialists, cannot legally or ethically defer or decline to treat or diagnose patients in order to first determine the insurance status of their patient.

¹ <https://www.aha.org/system/files/media/file/2019/04/040219-aha-fah-ama-to-reps-foxx-scott-on-surprise-billing-proposal.pdf>