Unanticipated 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 following principles are intended to help guide the development of policy in this area.

- **Insurer accountability.** Since overly narrow provider networks contribute significantly to this problem, strong oversight and enforcement of network adequacy is needed from both federal and state governments. Robust network adequacy standards include, but are not limited to, an adequate ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as maximum wait times and geographic and driving-distance standards. Provider directories must be accurate and updated regularly to be useful to patients seeking care from in-network providers. In addition, insurers should be held to complying with the prudent layperson standard in existing law for determining coverage for emergency care, so that insured patients are not liable for unexpected costs simply because they were unable to accurately self-diagnose ahead of time whether their symptoms were, in fact, due to an emergency medical condition.

- **Patient responsibility.** Patients should only be responsible for in-network cost-sharing rates when experiencing unanticipated medical bills.

- **Transparency.** All patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers, should be informed prior to receiving care about their anticipated out-of-pocket costs. When scheduling services for patients, providers should be transparent about their own anticipated charges, and insurers should be transparent about the amount of those charges they will cover.

- **Universality.** In general, any federal legislation to address unanticipated out-of-network bills should also apply to ERISA plans.

- **Setting benchmark payments.** In general, caps on payment for physicians treating out-of-network patients should be avoided. If pursued, guidelines or limits on what out-of-network providers are paid should reflect actual charge data for the same service in the same geographic area from a statistically significant and wholly independent database. They should not be based on a percentage of Medicare rates, which have become increasingly inadequate in covering overhead costs. Nor should they be based on in-network rates,

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which would eliminate the need for insurers to negotiate contracts in good faith. Any prohibition, whether state or federal, on billing from out-of-network providers not chosen by the patient should be paired with a corresponding payment process that is keyed to the market value of physician services.

- **Alternate dispute resolution.** Legislation should also provide for a mediation or sequential alternative dispute resolution (ADR) process for those circumstances where the minimum payment standard is insufficient due to factors such as the complexity of the patient's medical condition, the special expertise required, comorbidities and other extraordinary factors. ADR must apply to states and ERISA plans. Arbiters should not be required to consult in-network or Medicare rates when making final determinations regarding appropriate reimbursements.

- **Keep patients out of the middle.** So that patients are not burdened with payment rate negotiations between insurers and providers, physicians should be provided with direct payment/assignment of benefits from the insurer.

Ask your member of Congress to ensure that any legislation addressing unanticipated medical bills incorporated these principles.