ALTERNATIVE DISPUTE RESOLUTION:

The Policy Solution to Protect Patients from Unexpected Medical Bills

PFC
PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

What is a Surprise Medical Bill?

Each year, millions of Americans seek emergency care at a hospital, and they do their best to ensure that they seek care at an **in-network hospital** covered by their health insurance plan. However, even though patients receive care at an in-network hospital, they could be treated by an **out-of-network physician**, which may result in what is commonly referred to as a surprise or **balance medical bill.**

✱ The Problem

Most providers work hard to be in-network with insurance companies, since this is best for the patient, supports the practice's volume, provides faster payment, and ensures payment for services. These are important to hospital-based physicians, who treat all patients regardless of their insurance coverage or ability to pay for their care. While the vast majority of hospital-based physicians are in-network with the health plans in their market, not all physicians are in all networks.

✱ The Solution

No patient should ever receive a balance medical bill – period. Any solution to balance billing must:

- Hold patients harmless;
- Increase transparency and promote strong provider networks; and
- Ensure patients continue to receive the highest quality care.

✱ Why ADR

The ADR approach has proven success at the state level. Four years ago, New York implemented a bipartisan ADR solution that resulted in:

- Increased network participation;
- Fewer out-of-network claims; and
- Stable prices.

✱ The ADR Model

This successful model included the following key components:

- Patients are protected from price negotiations and only held responsible for their usual in-network cost-sharing in both emergency and non-emergency care;
- Plans and health care providers use arbitration to establish precedents for contract negotiations;
- Plans must fully and clearly disclose reimbursement levels to patients;
- Plans that offer out-of-network coverage must provide at least a minimum level of coverage for out-of-network services;
- Payments to providers are capped at the 80th percentile of charges through an independent unaffiliated database called FAIR Health, which was specifically created by New York for this purpose; and
- Patients have the ability to more easily submit out-of-network claims by requiring health plans to accept online submissions and providers to include claims in their billing.

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How the Proposed ADR Process Would Work

1

NO MORE SURPRISES

When a patient receives emergency or unanticipated out-of-network care, they would only be responsible for their in-network cost-sharing.

2

IDR PAYMENTS

For out-of-network bills, the insurer pays the provider an Interim Direct Reimbursement (IDR) based on contracted rates in that geographical region.

3

BASEBALL STYLE

If the plan or provider is not satisfied with the IDR, either party could opt to bring the dispute to binding "baseball style" arbitration to determine the final payment.

3

FINAL OFFERS

Providers and insurance companies would submit their "final offers" to an independent arbitrator who would decide based on the commercial insurance market.

CORE PRINCIPLES OF THE PROPOSED POLICY SOLUTION

✱ Strong Patient Protections

- Patients will not have to participate in billing discussions for unanticipated out-of-network services;
- Patients who receive unanticipated out-of-network care will not receive a balance bill;
- Patients' cost-sharing for unanticipated out-of-network services will be the same as required when they receive in-network services;
- Providers will discuss their out-of-network fees in advance of services, except when it is not possible, such as in cases of emergency services or unanticipated out-of-network care situations;
- Plans will explain in plain language their out-of-network coverage and any limitations; and
- Patients will be protected from the financial impact that can result from narrow networks.

✱ Increased Transparency

- Health insurance plans will provide accurate and up-to-date clinician directories in plain language, accessible online and in print; and
- Directories will include information on how the plan's network is built, how the network is organized, when referrals are needed, and customer service contact information.

✱ Fair Reimbursement

- The Health and Human Services (HHS) Secretary will establish an ADR process through a certified ADR entity or administrator independent of both plans and providers;
- Existing state law with an adequate process addressing out-of-network reimbursement will take precedent;
- In states without an applicable law, ADR entities will be established to resolve reimbursement issues between providers and health insurance plans for disputed amounts greater than $750;
- In states without an adequate process, providers or plans may petition the federal ADR entity to resolve the dispute;
- If charges are less than $750, the health insurance plan will reimburse directly to the clinician the clinician's charges and the patient's cost-sharing amounts;
- The charges cannot exceed the 80th percentile of all clinician charges in the same geographical area for the particular health care service performed by a health care professional in the same or similar specialty; and
- The geographical service area is based on an independent, nonprofit benchmarking database.