**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.
# Alternative Dispute Resolution: The Policy Solution to Protect Patients from Unexpected Medical Bills

## How the Proposed ADR Process Would Work

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td><strong>No More Surprises</strong>&lt;br&gt;When a patient receives emergency or unanticipated out-of-network care, they would only be responsible for their in-network cost-sharing.</td>
</tr>
<tr>
<td>2</td>
<td><strong>IDR Payments</strong>&lt;br&gt;For out-of-network bills, the insurer pays the provider an Interim Direct Reimbursement (IDR) based on contracted rates in that geographical region.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Baseball Style</strong>&lt;br&gt;If the plan or provider is not satisfied with the IDR, either party could opt to bring the dispute to binding &quot;baseball style&quot; arbitration to determine the final payment.</td>
</tr>
<tr>
<td>3</td>
<td><strong>Final Offers</strong>&lt;br&gt;Providers and insurance companies would submit their “final offers” to an independent arbitrator who would decide based on the commercial insurance market.</td>
</tr>
</tbody>
</table>

## 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.

### 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 healthcare service performed by a healthcare professional in the same or similar specialty; and
- The geographical service area is based on an independent, nonprofit benchmarking database.

### 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.