



“Surprise Medical Bills” Policy Imperatives: IDR with Previous In-Network Contracting History

Principles:

Legislation to address “surprise medical bills” should be based upon the following principles:

- Patients should be protected from surprise bills related to care by providers out of their plan network.
- Patients should be protected from unexpected personal out-of-pocket costs due to gaps in health benefit plans and should have easy access to accurate transparent information about pricing and provider networks.
- The emergency care system should be sustained, adequately compensated for availability, and uphold both the federal Prudent Layperson Standard and the Emergency Medical Treatment and Active Labor Act (EMTALA).
- A fair and balanced contracting environment should be provided to increase access to in-network care and encourage more robust networks in a variety of settings, especially in rural and underserved areas.
- A free market system of contracting between providers and plans should be maintained to prevent unintended consequences of harming patients, plans or those providers that have historically adopted an in-network approach to contracting. Appropriate differentials in reimbursement should be encouraged for higher quality, more efficient providers or those providing more complex or sub-specialized care.

Policy Imperatives:

Patient Protections – Patients should be financially protected and taken out of the middle of reimbursement disputes between insurers and providers. For emergency services and non-emergent unanticipated out-of-network care, providers should no longer be permitted to balance bill and patients should only be responsible for in-network cost-sharing requirements.

Independent Dispute Resolution (IDR) – Any solution should include a simplified accessible and meaningful appeals process in addition to an adequate interim payment.

- **Accessible** – IDR should be accessible. This can be achieved by 1) including NO threshold or 2) including a threshold with “batching” language that allows providers to combine multiple claims, including different CPT codes, from an entire provider group, over an adequate time period.
- **Meaningful** – Any IDR solution should include the **history of previous in-network contracting** between the plan and provider under dispute as the primary criteria of what is reasonable. If the two parties were not in contract previously, the criteria should be “commercially reasonable rates” or another appropriate range of commercial rates for similar services that avoids a benchmark. The arbiter should also consider differentiating criteria such as quality, complexity, site of care, and efficiency, among others.
- **Strengthening and Stabilizing** -- This policy would ensure the overwhelming majority of providers currently in-network remain in-network. If the prior contract is the main criteria in arbitration, there will be no incentive for plans or providers to go out-of-network seeking reimbursement drastically different than what they receive from their current privately negotiated rates. In short, this policy will encourage plans and providers to negotiate private contracts and strengthen networks, thus minimizing incentives for either side to be out-of-network.