



UNANTICIPATED MEDICAL BILLS

Americans continue to struggle with rising health care costs, including high deductibles and other out-of-pocket expenses. As such, a balanced solution for cost-sharing between patients, physicians and health plans is a priority for organized neurosurgery. Patients deserve access to the physicians of their choice which at times may require seeking care from out-of-network physicians. Unfortunately, the current health care delivery system, with its arcane rules, narrow networks, and lack of transparency, often leaves patients vulnerable. As physicians, we can, and must do better, to assure that our patients are not left with unanticipated medical bills that can soar into the thousands of dollars, leaving them financially vulnerable.

The problem of unanticipated out-of-network bills is complex, and requires a sensible solution. In addition to providing strong patient protections, we believe the principles set forth below would improve transparency, promote access to appropriate medical care, and avoid creating disincentives for insurers and health care providers to negotiate network participation contracts in good faith. As Congress develops potential legislation to provide relief to patients from health care costs that their insurance will not cover, the AANS and the CNS believe that the following shared principles of consensus should apply in all situations, whether the health plans are regulated by the states or federal government.

1. **Adopt network adequacy standards.** Insurers must meet appropriate network adequacy standards including, but not limited to, an adequate ratio of emergency physicians, hospital-based physicians, and on-call specialists and subspecialists to patients, as well as geographic and driving distance standards and maximum wait times. Provider directories must be accurate and updated regularly to be useful to patients seeking care from in-network providers.
2. **Physicians want to participate in health plan networks.** The vast majority of physicians, including neurosurgeons, want to participate in-network with insurance companies, but can only do so when insurers negotiate in good faith for fair reimbursement.
3. **Limit patient responsibility and keep patients out of the middle.** Patients who unknowingly receive treatment from an out-of-network hospital-based physician should be held harmless and not be financially penalized by an unanticipated gap in their insurance coverage. Rather they should only be responsible for in-network cost-sharing rates. So 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.
4. **Increase transparency for patients.** Insurers' high-deductible plans transfer more unexpected costs to patients who often choose options based on monthly premium costs without fully realizing the magnitude of their out-of-pocket expenses. The influx of large gaps in insurance coverage or surprise bills in this environment is as much the result of surprise coverage gaps, as it is balance billing. Insurers must clearly inform their enrollees of the limits of their coverage and, before scheduled procedures, provide enrollees with reasonable and timely access to in-network physicians. In addition, all patients who choose in advance to obtain scheduled care from out-of-network physicians, hospitals or other providers should be informed before 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.

5. **Medicare is not an appropriate payment benchmark.** Medicare is not an appropriate benchmark for determining out-of-network payment. Medicare amounts are politically driven to reimburse medical services for a specific population based on federal budgetary and regulatory constraints. Such a methodology does not determine appropriate payment in other contexts, such as payment for commercially insured services. Furthermore, Medicare payment rates have become increasingly inadequate in covering overhead costs and are not market rates.
6. **In-network rates are not an appropriate payment benchmark.** Participating provider contractual rates are not an appropriate benchmark for determining out-of-network payment. Contracted rates are negotiated rates for which the insurer promises consideration in exchange for access to a discounted price. If insurers can pay contractual rates for out-of-network services, there is no incentive for them to negotiate in good faith for fair reimbursement and in fact, this would serve only as motivation for insurers to drive down contractual rates even further.
7. **Out-of-network payments should include physician charges.** Basing out-of-network payments on reasonable physician charges for the same service in the same geographic area is vastly superior to any methodology based on a contrived Medicare rate or a rate completely under the control of the insurance company. The FAIR Health database is an example of a database of physician charges that is geographically specific, completely transparent, and independent of the control of either payers or providers. Utilizing the 80th percentile of the FAIR Health database to determine the minimum benefit standard would exclude the highest outlier physician charges from consideration and ensure that out-of-network payment is reflective of truly reasonable charges. Implementation of such a system would substantially decrease, if not eliminate balance billing, while simultaneously creating an incentive for commercial payers to increase their network.
8. **Arbitration should be permitted to resolve out-of-network billing disputes.** Health plans should be required to pay physicians a commercially reasonable rate within 30 days. If either the physician or health plan is dissatisfied with that amount, they should privately settle on a payment amount or resolve the dispute using a “baseball-style” arbitration process that bases payment on the usual and customary cost of the service referenced from an independent medical claims database.
9. **EMTALA limits any discussions of costs and insurance status.** All persons and entities involved in providing and financing health care have an obligation of transparency to patients and health care consumers. However, any discussion of transparency in the emergency setting must recognize that federal requirements under the Emergency Medical Treatment and Labor Act (EMTALA) statute provide that patients seeking emergency care have unfettered access to a diagnostic evaluation and stabilizing treatment without regard to their ability to pay, thus appropriately restricting any discussion of costs and insurance status until a patient is stabilized.
10. **A prudent layperson standard should be recognized.** Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

For More Information Contact:

Katie O. Orrico, Director
AANS/CNS Washington Office
25 Massachusetts Avenue, Suite 610
Washington, DC 20001
Office: 202-446-2024
Email: korrico@neurosurgery.org