



AMERICAN COLLEGE OF SURGEONS

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Surprise Medical Billing

Solutions to address unanticipated/surprise medical billing should keep patients out of the middle, provide a fair independent dispute resolution process, avoid the long-term consequences of setting payment benchmarks, increase the transparency of insurance plans, address network adequacy, and level the playing field between providers and insurers.

Surgeons, patients, and policymakers are concerned about the impact that unanticipated/surprise medical bills have on patient costs and the patient-physician relationship. The American College of Surgeons (ACS) believes any legislative efforts to address unanticipated/surprise medical bills should be comprehensive and focus on all root causes of the problem, without causing further harm to the health care system.

Protect Patients First

Patients should only be responsible for their in-network cost-sharing amounts when receiving unanticipated medical bills. Additionally, to preclude patients from being burdened with negotiations between insurers and providers, physicians should be provided with direct payment/assignment of benefits from the insurer.

Establish a Proven, Fair, and Equitable IDR

The ACS believes that the out-of-network law passed in the state of New York serves as a useful and workable template for federal legislation. This law strikes a careful balance among key health care stakeholders, including physicians, hospitals, and health insurers, and has proven successful in protecting patients from large unanticipated medical bills. The New York law includes an independent dispute resolution (IDR) process which allows the arbiter to review a variety of factors when making their determination. Such factors include the complexity of the service rendered, the experience of the physician providing the service, the rate that physicians charge for the service in a geographic area, and insurance data from an independent source. An accessible IDR mechanism should not be restricted to claims above a specific dollar amount and should allow for “batching” of claims for the same or similar service under the same insurance provider.

Concerns that the law would lead to increased payment rates have proven unfounded. According to a recent study from Georgetown University titled “New York’s 2014 Law to Protect Consumers from Surprise Out-of-Network Bills Mostly Working as Intended: Results of a Case Study,” the New York law, which uses a fair IDR model, is working well. In fact, the study found a 13 percent average reduction in physician payments since the law was enacted. Importantly, State regulators report that there has not been an indication of an inflationary effect in insurers’ annual premium rate filings.

Avoid Setting Benchmark Payment Rates

Guidelines utilized for payment should reflect actual charge data for the same service, in the same geographic area, performed by a qualified specialist or sub-specialist, and be sourced from a statistically significant and wholly independent benchmarking database maintained by a nonprofit organization. Medicare rates are inadequate for this purpose because they establish artificial rates based on budgetary constraints and policy agendas rather than market forces. Nor should rates be based on negotiated in-network rates, which would have

the effect of eliminating the need for insurers to engage in meaningful negotiations.

Various legislative proposals have set a payment benchmark at the median in-network rate, which will expand the disproportionate power that health plans have with physicians and will likely result in two major negative consequences. For those physicians who want to be part of the health plan's network, the ability to negotiate a payment rate with the health plan will be unfairly biased towards the plan. For those physicians who are currently in-network and paid above the median in-network rate, the health plan will have the unfettered power to lower the rate paid to those physicians with no realistic alternative for the physician.

Accepting a federally benchmarked rate, as some are advocating, could have a significant impact on the U.S. health care system as we know it today. Using rate setting to resolve this issue, could have a striking effect on all physician payment, and open the door to large scale health care reform in a way that requires further debate.

Improve the Transparency and Adequacy of Networks

The ACS maintains that proposed solutions must include increased transparency for insurers, requiring them to accurately update and make readily available their provider directories on a regular basis. In addition, insurers must be required to provide greater transparency with regards to deductibles and required cost-sharing amounts for both in-network and out-of-network care so that patients can make informed decisions when they are able to choose who will provide their care.

Health insurance plans often rely on narrow, inadequate networks of contracted surgeons, physicians, hospitals, and other providers as a mechanism of managing costs. These products are frequently deficient in key health care providers. Strong oversight and enforcement of network adequacy is needed from both the federal and state governments. Insurance plans must be mandated to meet minimum standards of network adequacy to include adequate numbers of surgeons, specialist and sub-specialist surgeons, emergency physicians, and hospital-based physicians, with consideration given to geographic and driving distance standards and maximum wait times.

Adding this level of transparency to the system and improving network adequacy will greatly assist patients and their care providers in avoiding unanticipated/surprise medical bills.

Congressional Ask

As Congress moves forward with its efforts to address this issue, we ask that the principles listed above be utilized to protect patients from unanticipated/surprise medical bills, promote access to appropriate medical care, and encourage insurers to negotiate in good faith with health care providers to establish adequate provider networks and fair remuneration.ⁱ

ⁱ Current to February 28, 2020. Please contact ahp@facs.org for an updated version.