



Unanticipated Medical Billing

As Congress develops legislation to address this issue, solutions should address network adequacy, level the playing field between providers and insurers, increase transparency of insurance plans, keep patients out of the middle, and provide for an alternative dispute resolution in certain cases.

Surgeons, patients, and policymakers are concerned about the impact that unanticipated medical bills have on patient costs and the patient-physician relationship. The American College of Surgeons (ACS) believes a holistic approach consisting of coordinated efforts by health insurance plans, hospitals, providers, and patients will be required to remedy this complex issue.

Too often, despite being diligent about seeking care from in-network providers, patients may find themselves receiving unanticipated bills from those who are not in their insurance plan's network. Much of the time, this is simply because patients had no way of accurately determining in advance all who would ultimately be involved in their care. Surgeons and other providers are also limited in their ability to help patients avoid these unanticipated costs because they are unable to accurately predict who will ultimately be involved in an episode of care, nor those individual's contract status with specific insurance plans.

Insurer Accountability

Insurers should be required to accurately update their provider directories on a regular basis in order to optimize their usefulness to patients seeking care from in-network providers. In addition, 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.

Health insurance plans often rely on narrow, inadequate networks of contracted surgeons, physicians, hospitals, and other providers. Insurance plans have chosen to offer these products with narrow, inadequate networks as a mechanism of managing costs. These products are many times deficient in key health care providers. Strong oversight and enforcement of network adequacy is needed from both the federal and state governments.

Protecting Patients

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.





Concerns with Benchmark Payments

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.

New York as a Model Solution

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. In addition to providing for comprehensive patient protections, the law also holds insurers accountable for maintaining adequate networks of physicians and specialists. In addition, the law establishes reasonable patient benchmarks and an effective alternative dispute resolution (ADR) for those circumstances where the payment offered is disputed due to factors such as the complexity of the patient's medical condition or special expertise required. This law seems to have struck the careful balance among key health care stakeholders, including physicians, hospitals, and health insurers, and has had success in protecting patients from large unanticipated medical bills.

Leveling the Playing Field

Over the past several decades, the health insurance market has become extremely concentrated. Antitrust exemptions and consolidation within the health insurance industry have facilitated the opportunity for fewer and fewer health plans to dominate the health insurance market. In many states, there may only be one dominant insurer for the entire private health insurance market. While these insurers are still subject to antitrust enforcement involving mergers and acquisitions under the *Clayton Act*, the *McCarran-Ferguson Act* separately created a federal antitrust exemption which allows insurers to share information on pricing. As a result, physicians are frequently placed in positions of diminished negotiating strength, and health plans are able to impose unilateral, essentially non-negotiable contracts. In order to establish more equity in negotiating power, Congress should remove restrictions currently in place on providers to jointly negotiate contracts.

Congressional Action

As Congress moves forward with its efforts to address this issue, we ask that the principles listed above be utilized to 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.¹

¹ Current to April 2, 2019. Please contact ahp@facs.org for an updated version.