QUESTIONS & ANSWERS
ABOUT SURPRISE MEDICAL BILLS

More than half (57%) of U.S. adults received a bill for medical services they thought were covered by health insurance, according to a 2018 survey by NORC at the University of Chicago. Patient access to needed physicians, particularly during emergencies, is negatively impacted by restrictive provider networks, out-of-date provider directories and physician reimbursement rates that don't cover the true cost of medical services. Stopping surprise medical bills will require more transparency and fairness.

What are surprise medical bills?
Surprise medical bills are unanticipated charges for services that patients receive from out-of-network physicians or other health care providers in situations when the patient would expect the services to be covered as in-network services.

What are the underlying causes?
Patients in the United States are feeling the impact of major changes to the health care marketplace that are having them pay a greater share of their health care expenses. Ever larger and more powerful insurance companies use different tools and approaches to save money, often at the expense of patients. A major factor in surprise bills' growth is insurers' narrow, or limited, provider networks, coupled with limited insurance coverage for out-of-network services. There is little to no regulatory oversight to ensure networks contain enough doctors so patients can access them when needed. This has led to more restricted access, especially to emergency physicians, surgeons and other specialists. When patients lack access to these physicians because they aren't in their insurance network, they can wind up with a large, surprise bill.

Why would a physician be out of an insurer's network?
In some instances, like restricted network plans, certain physicians and hospitals are not offered a contract. This presents challenges for physicians who generally prefer the predictability of being "in-network" to being "out-of-network," because of the various payment and administrative challenges associated with non-contracted status. In other instances, a physician or hospital may decide that the payment offered by an insurer is insufficient or that other contract terms are inappropriate from a clinical perspective. For physicians, insurers' offers are nearly always "take it or leave it" – there is rarely any negotiating ability to secure a fairer rate or address unfair contract terms. In those circumstances, it is important that physicians are able to exercise their right to not agree to contract terms that don't adequately cover the expense costs associated with their services or that they feel would undermine their ability to make appropriate medical decisions for their patients.

What policy approach should Congress take to address surprise medical bills?
Congress's approach must remove patients from billing disputes so they aren't held responsible for insurance company policies beyond their control. A comprehensive solution – one that addresses the root causes of the problem and creates a fair process for resolving disputes – is needed to ensure patients can access physician specialists when they are needed. This includes rigorous network adequacy standards and oversight to require appropriate access to in-network services for patients, reducing the likelihood of surprise medical bills. Patients need to be able to understand and rely on information regarding their insurance coverage and financial responsibilities associated with health care. Provider directories must be accurate, and plan descriptions regarding patients' financial responsibilities – particularly with regard to deductibles and coverage for out-of-network services – must be clearer. Patients must be given information about possible situations that would expose them to unanticipated out-of-network expenses.

When dealing with insurer-physician payment disputes for out-of-network services, an approach grounded in transparency and fairness to all parties is the most effective. Congress should model its legislation around a New York law enacted five years ago, which absolves patients from responsibility for surprise medical bills and addresses their root causes. The law's provisions are designed to ensure network adequacy and

transparency of information for patients regarding their potential financial responsibility for health care expenses under the terms of their plan benefits.

Why should Congress model New York's approach to resolving payment disputes for these services?
New York's approach requires insurers and physicians to settle disputes with "baseball-style" arbitration where the arbitrator must choose either the insurer's offered payment rate or the physician's billed charge and the loser pays. This time-tested approach incentivizes both sides to negotiate in good faith to avoid arbitration altogether, penalizing outlier billing practices or unreasonably low payment offers. In the case of unresolved disputes, the New York law directs the arbitrator to use benchmark data collected by an independent organization to determine which party – insurer or provider – should prevail. The arbitrator considers various important factors to make a determination, including: the "usual and customary costs" of services in the particular geographic area – defined as the 80th percentile of charges for that service in that region – with high-charge outliers eliminated; the physician's education and training; and the complexity of the patient's treatment.

Does the New York law work?
Yes. Numerous studies have concluded New York's model to resolve surprise medical bills works. Since the law went into effect, New York premiums have grown more slowly than the rest of the nation, and out-of-network charges are down 13 percent, according to a May 2019 Georgetown University Health Policy Institute case study. Importantly, disputes are being resolved before arbitration. When it occurs, decisions have been split evenly between physicians and insurers, an indicator that the law is encouraging fairness. Patients are kept out of the middle, giving them peace of mind that they won't be held responsible for bills they might struggle to pay.

Why doesn't a benchmark based on in-network rates work?
Congress needs to preserve patient access to necessary physician services by promoting fair negotiations over rates and other contract terms. A federally-established payment benchmark for out-of-network services that references in-network averages will, in time, significantly impact affected physician specialists' ability to serve patients. This approach would result in insurers having even less incentive to offer reasonable contract rates than they do currently. The affected medical specialties would suffer losses, patients would be impacted, and access to these much-needed specialty-level services would erode over time.

How can Congress solve this problem?
Congress should support the bipartisan proposal by U.S. Representatives Raul Ruiz, MD (D-CA), Phil Roe, MD (R-TN) and six colleagues, which uses New York's law as a policy framework.

CONGRESS: IMPROVE ACCESS TO NEEDED MEDICAL CARE:

- ✓ Remove patients from financial responsibility for surprise medical bills.
- ✓ Require a fairer, more transparent physician payment approach to prevent more provider consolidation, less choice in doctors and even higher prices for patients.
- ✓ Support the bipartisan Ruiz-Roe plan as a framework for legislation.

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