Alliance of Specialty Medicine

Sound Policy. Quality Care.

SURPRISE MEDICAL BILLS
Addressing the Impact of Narrow Networks

REQUEST

The Alliance of Specialty Medicine urges lawmakers to ensure that any legislative solution to address unanticipated medical bills includes an accessible, fair independent dispute resolution (IDR) and payment criteria that do ***not*** tie physician reimbursement to the median in-network rate.

PRINCIPLES FOR CONSENSUS LEGISLATION

As Congress works to develop consensus policy to address issues arising from out-of-network care, which can lead to surprise bills, the Alliance urges you to avoid unintended and harmful consequences for patients, providers, and the overall health care system. The Alliance urges that any consensus legislation incorporate the following principles:

- **Ensure insurer accountability** through robust network adequacy standards, including specialists and subspecialists;
- **Limit patient responsibility** to in-network rates and **keep patients out of the middle** so payment negotiations are between the health plan and provider;
- **Promote transparency** so patients are informed in advance of potential out-of-network charges;
- **Avoid setting a benchmark payment rate** for out-of-network providers. Payment rates must be commercially reasonable for the same service in the same geographic area from a statistically significant and wholly independent database (e.g., FAIR Health);
- **Provide independent dispute resolution** to address payment disputes between health plans and providers; and
- **Promote universality** by ensuring that ERISA plans are also covered.

BACKGROUND

Benchmark Payment – The Alliance urges Congress not to engage in federal rate setting by prescribing a benchmark payment for out-of-network providers. Payment rates must be commercially reasonable for the same service in the same geographic area from a statistically significant and wholly independent database (e.g., FAIR Health). A federal benchmark payment at the in-network negotiated rate fails to recognize fundamental legal tenets concerning the development of contracts. In-network rates are not market rates, but rather discounted rates based upon other favorable conditions within a negotiated contract (e.g., ease of payment, timely payment, access to a large pool of covered lives, etc.). By definition, the median in-network rate is lower than some negotiated rates for in-network providers and adds an incentive for health plans to eliminate providers who have higher negotiated rates from their network during the next contract negotiation — ultimately resulting in lower and lower in-network rates as well as smaller and smaller provider networks. This is confirmed by the Congressional Budget Office (CBO), which estimates that the utilization of the median in-network rate would cause the "average [provider payment] rate to drop by 15 percent to 20 percent at the national level." Such a reduction in provider payments has been estimated to total $50 billion a year. Thus, if the payment rate for out-of-network services is set by Congress to be the same as the median in-network payment rate, then insurers have very little incentive to create and maintain appropriate networks.

Independent Dispute Resolution (IDR) – Several states, including Arizona, Missouri, New Jersey, New York, and Texas, have enacted surprise medical bill laws that include IDR requirements for those circumstances where the minimum payment standard is not commercially reasonable or is insufficient due to such things as the complexity of the patient's medical condition, the special expertise required, comorbidities, and other extraordinary factors. New York's law, in particular, has been cited by stakeholders as a successful model for eliminating surprise medical bills, while at the same time allowing health plans and providers the ability to negotiate fair reimbursement. If the parties cannot agree, they may enter a low-cost (typically between $250 to $400), binding IDR process. Through this baseball-style arbitration, the IDR entity selects within 30 days ***one*** of the amounts submitted by the health plan or provider. The non-prevailing party pays for the costs of the IDR. IDR, which is only used as a back-up to address infrequent payment disagreements between health plans and providers, works well, has lowered out-of-network payment rates, and encouraged broader provider networks. Most importantly, the patient remains removed from the process as IDR is between the health plan and the provider.

Network Adequacy – Health plans should adhere to uniform, reliable network adequacy standards to provide patients with timely access to the right care, in the right setting, by the most appropriate provider. Networks should be sufficiently robust to ensure that an appropriate number of specialists and subspecialists per enrollee are available, and network adequacy standards should also take into consideration geographic and driving distance standards and maximum wait times. Finally, provider directories must be accurate and updated regularly to be useful to patients seeking care from in-network providers

Despite Federal regulations that require Qualified Health Plans (QHPs) to meet network adequacy standards as set by the National Association of Insurance Commissioners' (NAIC) Health Benefit Plan Network Access and Adequacy Model Act — which, among other things, bolsters the authority of state insurance departments to decide whether a network is adequate — few states have updated their laws to match the revised model law. Without minimum network adequacy standards, health plans continue to narrow their networks, and patients are surprised when their provider is not in-network, and ultimately, insurance does not fully cover their care.

Narrow networks are a central reason why physicians practice out-of-network and the root cause of many surprise bills. Unanticipated medical billing can only be addressed if health plans meet minimum standards of network adequacy.