CONSENSUS PRINCIPLES ON INSURANCE COVERAGE FOR OUT-OF-NETWORK CARE PROVIDED BY HOSPITAL-BASED PHYSICIANS

Supported by:
American Academy of Orthopaedic Surgeons
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American College of Emergency Physicians
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When insured patients are treated in the hospital, they should be confident in the knowledge that their health insurance will cover them. Unfortunately, a growing number of these patients are finding out too late that their coverage is far less comprehensive than they thought. Increasingly, insurers are making unsuspecting patients responsible for additional payments of covered services provided by hospital-based physicians who are not in their insurer's network. Insurers have been further worsening this problem by enticing consumers to enroll in plans with ever-growing deductibles and ever-narrowing networks of providers. These are intentional business decisions by the insurers that allow them to reduce costs by shifting significantly more of the cost-sharing burden onto patients and by limiting the pool of physicians in their networks to those who agree to contract at greatly reduced rates that may be well below market value. Since the insurance industry is intensifying its efforts to narrow networks further and force more physicians out of network, we believe a fair and equitable solution to the out-of-network balance billing issue should be developed that protects unsuspecting patients from facing significant financial hardships simply because the hospital services they needed at that moment were provided by an out-of-network physician. The following shared principles of consensus are agreed to and will be supported by hospital-based physician specialties:

1. Insurers must meet appropriate network adequacy standards that include adequate patient access to specialty care, including access to hospital-based physician specialties. State regulators should uphold such standards in approving health insurance company plans.

2. 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 EMTALA statutes 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.

3. The vast majority of physicians want to participate in network with insurance companies, but can only do so when insurers negotiate in good faith for fair reimbursement.

4. 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, prior to scheduled procedures, provide enrollees with reasonable and timely access to in-network physicians.

5. Patients who unknowingly receive treatment from an out-of-network hospital-based physician should not be financially penalized by an unanticipated gap in their insurance coverage. The need for (and practice of) balance billing these patients can be eliminated if replaced with a fair and effective minimum benefit standard based on reasonable physician charges for the same service in the same geographic area.

6. Physician triggered mediation should be permitted in those instances where their unique background or skills (i.e. the Gould Criteria) are not accounted for within a minimum benefit standard.

7. Medicare is not an appropriate benchmark for determining out of network payment. Medicare amounts are politically derived for the purpose of reimbursing 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. In addition, for some specialties, billing practices and amounts are not tied to Medicare.

8. 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.

9. Basing out of network payments on provably 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 80^{th} 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.

10. 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.