INDEPENDENT DISPUTE RESOLUTION:

The Policy Solution to Protect Patients from Unexpected Medical Bills

PFC
PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

What is a Surprise Medical Bill?

Each year, millions of Americans seek emergency care at a hospital, and they do their best to ensure that they seek care at an **in-network hospital** covered by their health insurance plan. However, even though patients receive care at an in-network hospital, they could be treated by an **out-of-network physician**, which may result in what is commonly referred to as a surprise or **balance medical bill.**

The Problem

Most providers work hard to be in-network with insurance companies, since this is best for the patient, supports the practice's volume, provides faster payment, and ensures payment for services. These are important to hospital-based physicians, who treat all patients regardless of their insurance coverage or ability to pay for their care. While the vast majority of hospital-based physicians are in-network with the health plans in their market, not all physicians are in all networks.

The Solution

No patient should ever receive a balance medical bill – period. Any solution to balance billing must:

- Hold patients harmless;
- Increase transparency and promote strong provider networks; and
- Ensure patients continue to receive the highest quality care.

Why IDR

The IDR approach has proven success at the state level. In 2015, New York implemented a bipartisan IDR solution that resulted in:

- Increased network participation;
- Fewer out-of-network claims; and
- Stable prices.

The IDR Model

This successful model included the following key components:

- Patients are protected from price negotiations and only held responsible for their usual in-network cost-sharing in both emergency and non-emergency care;
- Plans and health care providers use arbitration to establish precedents for contract negotiations;
- Plans must fully and clearly disclose reimbursement levels to patients;
- Plans that offer out-of-network coverage must provide at least a minimum level of coverage for out-of-network services;
- Payments to providers are capped at the 80th percentile of charges through an independent unaffiliated database called FAIR Health, which was specifically created by New York for this purpose; and
- Patients have the ability to more easily submit out-of-network claims by requiring health plans to accept online submissions and providers to include claims in their billing.

INDEPENDENT DISPUTE RESOLUTION:
The Policy Solution to Protect Patients from Unexpected Medical Bills

How the Proposed IDR Process Would Work

1

NO MORE SURPRISES

When a patient receives emergency or unanticipated out-of-network care, they would only be responsible for their in-network cost-sharing.

2

IDR PAYMENTS

For out-of-network bills, the insurer pays the provider an Interim Direct Reimbursement based on contracted rates in that geographical region.

3

BASEBALL STYLE

If the plan or provider is not satisfied with the IDR, either party could opt to bring the dispute to binding "baseball style" arbitration to determine the final payment.

3

FINAL OFFERS

Providers and insurance companies would submit their "final offers" to an independent arbitrator who would decide based on the commercial insurance market.

CORE PRINCIPLES OF THE PROPOSED POLICY SOLUTION

✱ Strong Patient Protections

- Patients will not have to participate in billing discussions for unanticipated out-of-network services;
- Patients who receive unanticipated out-of-network care will not receive a balance bill;
- Patients' cost-sharing for unanticipated out-of-network services will be the same as required when they receive in-network services;
- Providers will discuss their out-of-network fees in advance of services, except when it is not possible, such as in cases of emergency services or unanticipated out-of-network care situations;
- Plans will explain in plain language their out-of-network coverage and any limitations; and
- Patients will be protected from the financial impact that can result from narrow networks.

✱ Increased Transparency

- Health insurance plans will provide accurate and up-to-date clinician directories in plain language, accessible online and in print; and
- Directories will include information on how the plan's network is built, how the network is organized, when referrals are needed, and customer service contact information.

✱ Fair Reimbursement

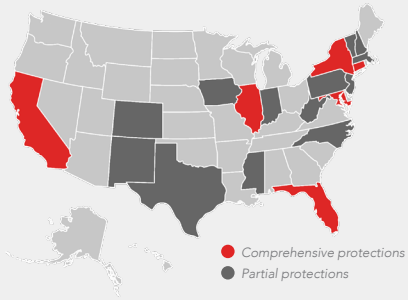
- The Health and Human Services (HHS) Secretary will establish an IDR process through a certified IDR entity or administrator independent of both plans and providers;
- Existing state law with an adequate process addressing out-of-network reimbursement will take precedent;
- In states without an applicable law, IDR entities will be established to resolve reimbursement issues between providers and health insurance plans for disputed amounts greater than $750;
- In states without an adequate process, providers or plans may petition the federal IDR entity to resolve the dispute;
- If charges are less than $750, the health insurance plan will reimburse directly to the clinician the clinician's charges and the patient's cost-sharing amounts;
- The charges cannot exceed the 80th percentile of all clinician charges in the same geographical area for the particular health care service performed by a health care professional in the same or similar specialty; and
- The geographical service area is based on an independent, nonprofit benchmarking database.

NEW YORK'S SUCCESSFUL APPROACH TO PROTECT PATIENTS FROM COSTLY, UNEXPECTED MEDICAL BILLS

PFC
PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

What is a Surprise Medical Bill?

Each year, millions of Americans seek emergency care at a hospital, and they do their best to ensure that they seek care at an **in-network hospital** covered by their health insurance plan. However, even though patients receive care at an in-network hospital, they could be treated by an **out-of-network physician**, which may result in what is commonly referred to as a surprise or **balance medical bill.**



STATES WORK TO FIND SOLUTIONS.
The results are in.

Of the 11 states that have enacted legislation to address balance billing, **New York's model offers a proven, successful solution compared to models implemented in other states.** An Independent Dispute Resolution (IDR) process with binding "baseball-style" arbitration works for patients, providers, and payers.

Defining IDR

An IDR process with arbitration will:

- Protect patients from any dispute between a provider and health plan by removing them from the process entirely;
- Incentivize out-of-network health care providers and insurance companies to meet at the negotiating table and, importantly, stay there; and
- Create and preserve a balanced negotiating dynamic between health insurance plans and providers.

IDR's Success in New York

In 2015, New York implemented a bipartisan IDR solution based on a binding "baseball-style" arbitration approach that included the following key components:

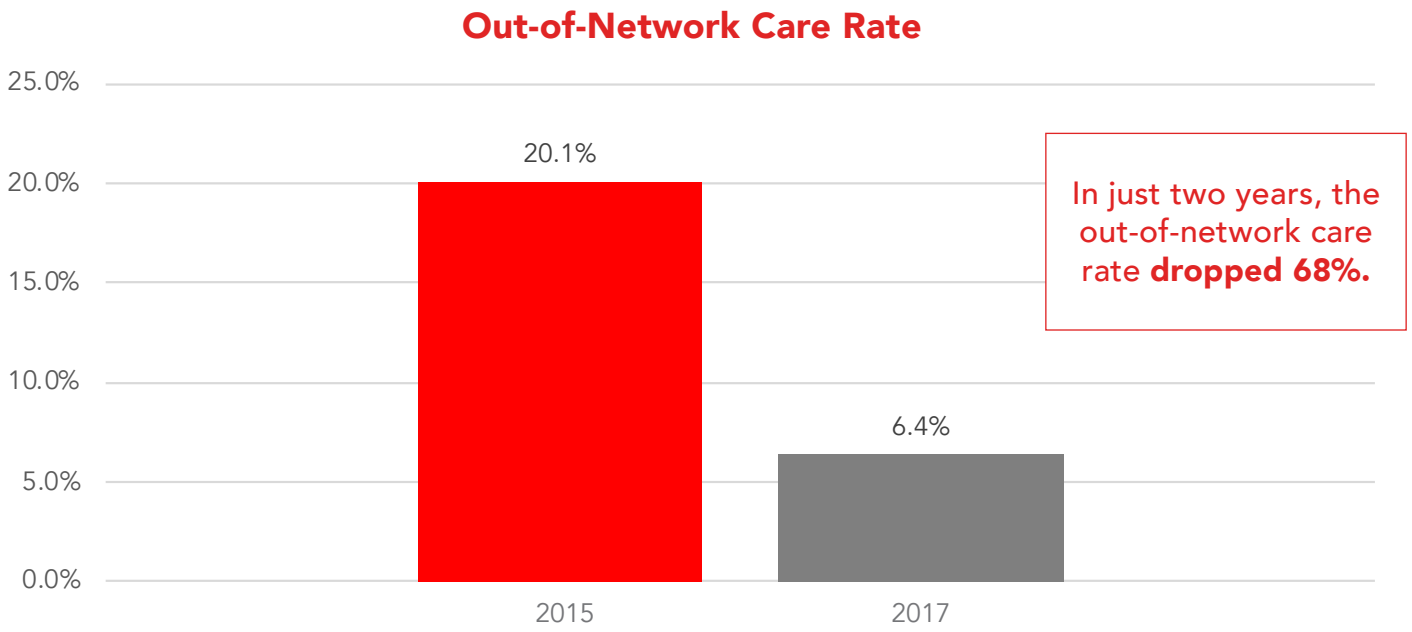
- Patients are protected from surprise medical bills and only held responsible for their usual in-network cost-sharing in both emergency and non-emergency care;
- Plans and health care providers use arbitration to establish precedents for contract negotiations;
- Plans must fully and clearly disclose reimbursement levels to patients;
- Plans that offer out-of-network coverage must provide at least a minimum level of coverage for out-of-network services; and
- Patients have the ability to more easily submit out-of-network claims by requiring health plans to accept online submissions and providers to include claims in their billing.

NEW YORK'S SUCCESSFUL APPROACH TO PROTECT PATIENTS FROM COSTLY, UNEXPECTED MEDICAL BILLS

A Look at the Key Takeaways

Since New York implemented its arbitration policy, there has been a dramatic reduction in the number of patients receiving out-of-network care: (1) In 2015, the rate of patients receiving out-of-network care was 20.1 percent.[1] (2) Two years after implementation, that rate plummeted to 6.4 percent. This is a 68 percent decrease.[1]

THE DATA IS CLEAR – NEW YORK'S MODEL IS WORKING



Over time, arbitration has pushed insurers and providers toward an equilibrium in arbitration cases.

- When the process was first implemented, insurers were able to combat high outlier charges by providers. But by 2018, market behavior had adjusted, and providers and insurers have reached a near balance in prevailing in arbitration cases.

Prices for emergency services have remained stable in New York.

- Not only have prices remained relatively stable for common emergency room procedures, but also despite what many have argued, this IDR process has not resulted in higher charges in New York.
- The 80th percentile of emergency room service values in New York from November 2015 to November 2018 show stability in prices, and even some decreases year-to-year.[2]
- Using a benchmark in the IDR process does not result in gaming by providers.[2]

An IDR model does not drive up in-network negotiated rates, and in fact has been found to bring them down.

- According to recent research, "Surprise! Out-of-Network Billing for Emergency Care in the United States," from Zack Cooper of the Yale School of Public Health, the New York law did not increase in-network emergency payments.

1 New York Department of Financial Services 2 March 2019 report from FAIR Health, "Teasing Apart the Threads to the Surprise Billing Debate,"

RATE SETTING MISSES THE MARK

Medicare is not an appropriate benchmark for determining out-of-network payments

PFC
PHYSICIANS FOR FAIR COVERAGE
PHYSICIANS PARTNERING WITH PATIENTS

Why?

The Medicare program was established for the purpose of reimbursing medical services for an age-specific population, and, as such, rates do not appropriately reflect key health services, such as obstetrics and pediatrics, for those under 65.

Reimbursement rates are based on federal budgetary and regulatory constraints, and, all too often, on major political considerations.

Medicare rates were never designed to represent the fair market value of health care services, or to even cover provider costs, and are consistently set below market rates. As such, they do not account for the significant financial burdens that physicians, particularly emergency doctors, face, including: Disaster response preparedness, boarding and managing admitted patients in the emergency department (ED) until in-patient beds are available, and staffing physicians for surge capacity.

✱ Medicare rates have not kept pace with the general costs of inflation.

Medicare rates today are

20% LESS THAN

Medicare rates in

1992

In emergency departments,

70%

OF PATIENTS DON'T COVER COSTS OF THEIR CARE

Today, physicians are paid

20 CENTS

ON THE DOLLAR

for the same procedures as they were in

1992

✱ Because emergency department physicians will provide care regardless of a patient's ability to pay, commercial insurance payments have historically made up for these significant losses. If commercial payment rates are linked to Medicare, one of two things will happen:

- Access to emergency services will be restricted; or
- The taxpayer will need to step in to make up for the shortfall.

✱ Utilizing a politically-derived funding methodology like Medicare will do serious damage to the health care safety net.

RATE SETTING MISSES THE MARK

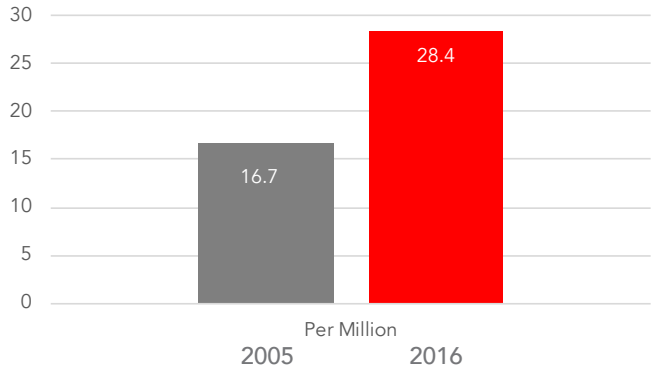
Medicare is not an appropriate benchmark

Using artificially low Medicare rates for determining out-of-network reimbursement will remove any incentive for insurers to negotiate fairly to bring physicians in-network. Many doctors will not be able to sustain their practices or provide the levels of access their communities need. This is particularly true in rural areas already experiencing physician shortages and hospital closures.

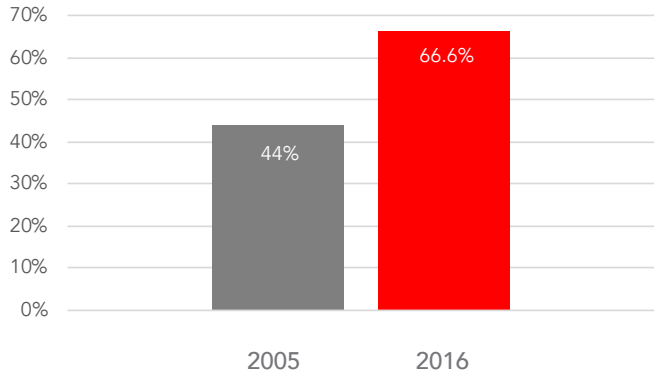
✱ The role of commercial rates in the health care market

- Patients with commercial health insurance should have their care paid for at commercial rates, comparable to their similarly situated peers with commercial insurance plans.
- Using Medicare rates as a benchmark will give insurers an incentive to walk away from negotiations to bring providers in-network, which will upset the rest of the market where negotiations have been successful.
- Additionally, commercial rates sufficiently allow a range of payment precision that reflects provider experience, quality, and the intensity of services in a way that Medicare rates cannot. Medicare rates also ignore the high degree of variability in the difficulty and cost intensity of providing clinical services across geographies and facility types – such as high acuity tertiary care vs. outpatient settings.
- Simply using Medicare rates ignores that the Medicare fee schedule itself is modified for providers through a variety of quality and value-based incentive programs.
- Finally, the Government Accountability Office (GAO), the non-partisan investigative arm of Congress, has established that Medicare significantly underpays physicians, in particular specific practice groups, like anesthesiologists.

More people in rural America are going to the emergency room



Rural emergency rooms are taking care of more uninsured patients



1 https://www.census.gov/newsroom/press-releases/2016/cb16-210.html 2 https://news.aamc.org/patient-care/article/data-aamc-consumer-survey-health-care-access/

Visits to emergency departments in rural areas jumped

MORE THAN 50%

in a decade, even as the overall population in rural areas fell

ONLY 12%

of primary care physicians are working in rural areas[1]

+

and the number of doctors per capita is declining[1]

2016 data revealed Americans living in rural communities

7 TIMES MORE LIKELY

to say that they were never able to get the health care that they needed [2]