New Mexico Society of Anesthesiologists

Out-of-Network Payment Toolkit:
Talking Points

Background

- This year, the vast majority of states considered out-of-network payment related legislation including requirements for cost estimates delivered to patients prior to procedures, prohibitions against balance billing, and determining dispute resolution measures.

- Out-of-network payment, also commonly termed "surprise bills" or "balance billing," is a high level issue of concern for ASA, state component societies, large group practice entities, and a growing number of stakeholders including medical specialty organizations, insurers, patients and consumer groups, large group practices, and others.

- Out-of-network payment occurs when a patient receives a bill for the remaining amount between an out-of-network provider's fee and the amount contributed by the patient's insurer after copay and deductibles.

- The focus of concern with out-of-network payment is that patients often assume facility-based providers will be covered similarly to their in-network surgeon and hospital, which is not always the case.

- Prohibitions on balance billing disincentivize insurers to engage in objective negotiations with health care professionals.

Cause of the Problem

- The vast majority of physicians want to be in-network. With networks narrowing and tiering, the frequency of surprise bills is increasing.

- Insurance companies are failing to create adequate and readily accessible networks. By tiering and progressively narrowing the networks that they create, insurance companies are only exacerbating the problem that originated from changes in health insurance introduced by them.

Solutions

- Maintaining accessible networks with adequate numbers of all providers and all services, as well as a mechanism for fair out of network payment are the keys to solving this problem.

- Physician organizations across the country are working together to promote the rights of patients to have well-defined, effectively communicated, easily understood, and fair minimum standard benefits.

- Benchmarking is one primary area of the discussion often most confused.
    - Health plans want Medicare and/or in-network rates as a benchmark and oppose anything charge related.
    - The U.S. Government Accountability Office (GAO) has already confirmed that Medicare underpays physician anesthesiologists.[1]
    - ASA's 2016 Survey Results for Commercial Fees Paid for Anesthesia Services demonstrates this problem still exists.[2]

- Benchmarking to a non-conflicted/independent database of billed charges within a specific geographic region for a specific service is the preferred approach.
    - In-network rates are not appropriate as they offer a discounted price based on promise of volume.
    - FAIR Health has been cited as an example of a database that could be appropriately used. It was established as a result of a lawsuit against the insurance carriers that were found to be deliberately manipulating data to their advantage.

For public comments please email communications.osi@state.nm.us by March 15, 2018.

[1] Government Accountability Office (2007, July). Medicare Physician Payments: Medicare and Private Payment Differences for Anesthesia Services (Publication No. GAO-07-463). Retrieved from GAO Reports Main Page via Reports & Testimonies database: http://www.gao.gov/products/GAO-07-463

[2] ASA Survey Results for Commercial Fees Paid for Anesthesia Services. Stanley W. Stead, M.D., M.B.A; Sharon K. Merrick, M.S., CCS-P. ASA Monitor. 2016; 80(10):58-65.