AMERICAN SOCIETY OF PLASTIC SURGEONS®
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ASPS POSITION STATEMENT

Out of Network Billing

Physicians Deserve Fair Payment. Patients Deserve Protection.

THE PROBLEM – INADEQUATE NETWORKS AND SURPRISE BILLS

Combined with inaccurate network directories and caps on payments for medical care, the phenomenon of shrinking insurance networks has contributed to the phenomenon of patients receiving large, unexpected bills at an unacceptable rate. The rise of these "balance bills" and "surprise bills" has led to growing scrutiny from legislators, regulators and the media. That scrutiny has resulted in a wave of proposed or implemented policy responses in a number of states.

Unfortunately, these responses focus too heavily on physician billing practices and not nearly enough on another crucial part of this problem – insurance companies' selling inadequate products and failing to appropriately disclose the realities of the coverage their customers are purchasing. The American Society of Plastic Surgeons (ASPS) believes a different approach to out-of-network billing is needed, where physicians are paid fairly and patients are better informed.

THE SOLUTION – INFORMED PATIENTS

Patients need to be fully informed of their potential to receive care from out-of-network providers, and ASPS believes payers, facilities and providers are all responsible for communicating network-related information.

- INSURER DISCLOSURE – Because patient interaction with out-of-network providers is fundamentally a network adequacy issue, health benefit plans are most responsible for increased incidence of balance and surprise billing. As such, insurers should take the lead in protecting their customers from surprise bills by providing enrollees, at every critical juncture, with notice that, at minimum –
    - Discloses that they may receive out-of-network care at an in-network facility.
    - Warns that they may be billed for the balance of an out-of-network provider's fee.
    - Lists of all the plan's participating facility-based providers.
    - Flags any request for pre-certification of services submitted by an out-of-network provider.
    - Details potential enrollee balance bill payment responsibilities based on coinsurance and the insurer's usual and customary out-of-network payment rates.
    - Explains the enrollee's right to assign future payments to non-participating providers.

- FACILITY DISCLOSURE – facilities are well-positioned to inform their patients of potential interactions with out-of-network providers and give them opportunity to make adjustments to avoid balance bills. To achieve this, facilities should, at the first non-emergency encounter, give patients notice of, at minimum –
    - Every facility-based provider or group with medical staff privileges at the facility.

- All insurance plans with which they participate, and any employed providers or contracted physician groups that do not participate in those plans.

- PROVIDER DISCLOSURE – facility-based providers also have a role in addressing this problem, most critically by reducing the confusion patients feel when they actually do receive a balance bill. When billing a patient for non-emergency out-of-network services, a physician should, at a minimum, give clear notice that –
  - The physician is not covered by patient's health plan.
  - The patient's health benefit plan has paid a rate below the physician's billed amount.
  - Explains remedies available to the patient, including alternative payment agreements and options for assignment.

THE SOLUTION – FAIR PAYMENT

Physicians who provide care to a patient on an out-of-network basis must receive fair payment, because physicians who are fairly reimbursed for their services are less likely to balance bill. Fair payment will only come about if it is a focus of out-of-network billing policy responses, and ASPS considers the following to be essential components of a system seeking fair compensation:

- A BALANCE BILLING OPTION – many legislative proposals ban balance billing outright. This is an unfair giveaway to insurance companies that forces doctors to accept artificially low reimbursements for their services. A better approach is to allow balance billing in instances when a patient has been adequately informed that they could be seeing an out-of-network provider, and instead focus on ensuring that physicians' bills and payers' reimbursements are appropriate and adequate.

- PATIENT PROTECTIONS – patients who receive a surprise bill should be allowed to retroactively assign benefits to the provider. This removes them from the process of resolving billing disputes.

- A THIRD-PARTY FEE SCHEDULE – current approaches to resolving billing disputes often impose a poorly-structured set fee schedule that advantage payers. In many cases, such fee schedules use payer-defined rates or Medicare reimbursement levels as a starting point for setting reimbursement. The former approach is problematic lets one side in the dispute – the payer – dictate the outcome using proprietary data, while the latter approach is problematic because Medicare rates are notoriously low.

  A better, alternative approach would be to use an independent third party claims data repository to set the fee schedule, and ASPS believes that the track record of using one such repository, FAIR Health healthcare claims data, makes a good benchmark for future policy development. FAIR Health is an independent not-for-profit that provides objective healthcare cost information to all interested stakeholders. It has the nation's largest collection of privately billed medial claims data, and its healthcare cost information is organized geographically, allowing it to provide relevant cost information that is regionally specific.