**PROPOSED LEGISLATIVE SOLUTIONS:**

**INSURANCE COVERAGE FOR OUT-OF-NETWORK CARE PROVIDED BY**

**HOSPITAL-BASED PHYSICIANS**

**Supported by:**

**American College of Emergency Physicians**

**American College of Radiology**

**American Society of Anesthesiology**

**This document outlines those provisions that should be included in any legislation designed to address out of network reimbursement and some options for dealing with the issue. These suggested strategies are intended to be for general guidance only; state-specific laws/issues might mandate that some considerations be changed. States should take steps to assess what policies will work best in their given political climate. Consultation with knowledgeable counsel and professional advisors is highly recommended.**

1. If legislation is likely to restrict balance billing, the following provisions should be included:
   1. A defined transparent, enforceable, and acceptable minimum benefit standard (MBS) for out of network services.
   2. With a Connecticut styled MBS, mediation may not be necessary as patients are protected from billing amounts (except for their co-insurance and/or deductible [collectively “cost sharing”]) and insurance companies must reimburse the MBS. [[1]](#endnote-1)

* 1. If an MBS is not achieved and mediation is required, a requirement that mediation be conducted by qualified professionals with healthcare claims experience, that it be resolved within 30 days of dispute submission, and that physicians can present multiple claims in a single hearing with an insurer so that they don’t have to incur the time and expense of disputing each claim individually. Also any dollar threshold, above which mediation would be permitted, e.g. Texas, should be determined per CPT code and not per patient encounter. Plans should be prohibited from sending false, misleading, or confusing information in EOB’s to patients.
  2. Insurers should be required to pay the health care provider directly rather than send the payment to their consumer and to pay the claims as billed and coded.

1. Provisions to consider including in legislation expressly prohibiting balance billing:
   1. Accepting a plan in which a minimum benefit standard for out of network payment is the 80th percentile of an independent database by geographic region (such as FAIR Health).
   2. Using a dollar threshold to define when an OON claim must be paid in full or is subject to mediation (e.g. Texas $500 threshold for health insurance companies, patients or providers to utilize mediation.[[2]](#endnote-2)) This threshold should be clearly defined to be **after** determination by the plan of the OON allowable or MBS, the patient’s deductible, co-insurance and/or co-payments (i.e. a threshold for adjudicating a balance bill).
   3. Using for all hospital based services the “greatest of three” standard such as was included in recent Connecticut legislation for emergency services, should include a clear definition for the second standard (what the plan usually pays for OON benefits) as being based on the lesser of the provider’s charge or the 80th percentile of usual and customary charges (using a FAIR Health type database).
   4. Regarding the legislative approaches described in 2(a) and 2(c), a provision could be added to allow physicians in rare instances involving extraordinary circumstances related to the nature and scope of the services provided, to pursue a mediation process if the physician believes that the MBS does not adequately reflect the value of those services. Such a mediation process must be in accordance with the standards described above.

1. [Connecticut Public Act 15-146 Section 9(b)(3)](https://www.cga.ct.gov/2015/act/pa/pdf/2015PA-00146-R00SB-00811-PA.pdf) [↑](#endnote-ref-1)
2. [Texas Insurance Code Title 8, Subtitle F, Chapter 1467](http://www.tdi.texas.gov/consumer/cpmmediation.html) [↑](#endnote-ref-2)