Guiding Principles for An Effective Balance Billing Solution

a) **Patient Protection.** Patients should be assured affordable access to emergency services as they are needed. However, to the greatest extent possible, patients should also be protected from large and uncertain costs arising from their need for emergency care and other involuntary use of services from out-of-network providers, including large costs arising from balance billing.

b) **Support for healthcare networks.** Provider participation in health plan networks provides an effective mechanism for plans and providers to work cooperatively, both to improve efficiency and to improve quality (e.g., through plan review of provider credentialing and programs that align payment with the quality and efficiency of care). Patients benefit when providers join health plan networks because this leads to negotiation of mutually acceptable reimbursement rates in advance of the need for services and because it eliminates the possibility of balance billing. Therefore, any changes in reimbursement for out-of-network coverage should preserve the incentives for providers to participate in health plan networks. Any proposed solution should not require that out-of-network providers be paid directly. In addition, any solution should encourage members to utilize in network providers in order to maximize their benefits and to preserve the integrity of the networks.

c) **Feasibility.** Any new rule should be workable, with private parties having reasonable and timely access to sufficient information to ensure compliance. No solution should be administratively or financially burdensome for either the provider or insurer. The use of a well-defined methodology for determination of a reimbursement rate, e.g. a percentage of Medicare, avoids placing all the leverage on either the provider or the insurer side, as occurs without a payment standard. The method for determination of the rate of payment should be set forth in the new rule thereby mitigating the need for negotiation or arbitration to establish rates.

d) **Appropriate provider compensation**. Providers must be assured adequate compensation for their services but should not be permitted to collect unreasonably large charges from health plans when a patient facing a health emergency appropriately uses an out-of-network provider. Percentage of charge methodologies is inherently flawed and inappropriate because the artificial construct of a charge master bears no reality to the true cost of performing the service. In addition, compensation for emergency services and for out-of-network care should be addressed separately.

e) **Appropriate respect for private decisions.** To the greatest extent possible, while taking account of other policy goals, rules should be designed to interfere as little as possible in the

relationship between patients, health plans, and providers. In particular, regulatory solutions should be used only to solve substantial problems, and only when market solutions are proven to be inadequate. If a policy decision is enacted that replaces market interactions with regulation, the displacement should be narrowly targeted to achieve the policy goals in a manner that causes the fewest unintended consequences and creates the greatest benefit for consumers. If an issuer and provider have an effective mechanism in place for resolving these types of disputes, it should remain in place.

f) **Appropriate disclosures to consumers.** Consumers must be adequately informed regarding the network status of providers. Consumers should be informed by both the providers and the insurers.

g) **Limited Scope**. Government driven out-of-network proposals should be limited to invisible provider (defined as an out-of-network provider delivering services in an in-network setting) situations and emergency services. These situations pose unique challenges for consumers as they can be exposed to an out-of-network provider without knowledge or choice. Proposals should also recognize the differences between emergency and invisible provider out-of-network experiences and develop guidelines that consider such differences. Tiered or select networks, however, should remain outside the scope of out-of-network proposals. All providers in a tiered network are in-network providers and consumers remain protected from exposure to excessive charges and provider balance billing.