

ENSURING ADEQUATE INSURANCE NETWORKS

Increasingly, health insurance plans are offering narrow, often inadequate networks of health care providers, leaving even the most diligent patient with out-of-network health care bills. **These narrow networks lead to “surprise” medical bills, most often occurring when patients receive care they thought was covered by their insurance, but was unexpectedly provided by an out-of-network physician.** For example, a particular hospital may be in network, but the surgeon providing the care may not be covered. Surprise bills can happen at any time, but they often happen during emergency care, when patients and doctors have no way of confirming who is in or out of network.

To solve this problem, Congress should set clear standards for network adequacy and enforce a system that provides fair payment to physicians while holding patients harmless. Without a transparent and fair rate, insurance companies manipulate costs without any market check.

When insurers have no incentive to negotiate in good faith, networks will become even smaller, further limiting access to care for patients. If physician practices go out of business or move, patients will have less access to care and community jobs will be negatively impacted.

AAOS Principles:

- **Ensure adequate insurance networks.** Incorporate specific, quantitative standards that require insurance networks to maintain a minimum number of active physicians, accurate physician directories, and provide transparent out-of-network options for patients. One orthopaedic surgeon in a state is an extreme example of an all too common “narrow network.”
- **Take patients out of the middle.** Patients must be held harmless, with carriers reimbursing providers directly and avoiding confusion caused by misunderstood reimbursements to patients.
- **Retain a balance billing option.** In nonemergent situations, balance billing should be permitted if the patient is adequately informed about the likelihood of out-of-network care. The patient should have every opportunity to seek care from an in-network provider in order to preserve choice and competition.
- **Ensure fair and timely payment.** Plans must use a truly independent database to determine usual and customary rates. By setting payment to “median in-network amounts” insurers have little incentive to contract with on-call providers as they can rely on the statutory rate.
- **Maintain uniformity of self-insured health plans.** Avoid creating a patchwork of 50 different standards for health insurance plans, leading to administrative and compliance burdens.

What Congress Should Do:

Congress should revise proposed federal legislation to incorporate the principles listed above and ensure that patients have access to broad, comprehensive insurance networks to avoid surprise medical bills.