AMAC Action Recommendation for Surprise Medical Billing Arbitration

Protect Patients from Surprise Medical Bills by Establishing a Fair and Equitable Arbitration Process

Americans should not receive a surprise bill when receiving medical treatment at an in-network hospital or surgery center. Several proposals have been introduced in Congress, AMAC Action believes the best proposal has the following characteristics:

- Do not use "usual and customary" verbiage because it will prevent the arbiter from starting with a reasonable provider charge and thus empower insurance companies to set a rate of their choosing.
- Remove the incentive for insurance companies to use repricing companies in order to negotiate a reduction after they've accepted an out-of-network provider's claim by ensuring that payment for care is made directly to the provider. In the case of some self-insured organizations, when a provider refuses to negotiate, the insurance company pays them a lower rate while the insurer keeps the difference between what was removed from the self-insured health plan and what was paid to the providers.
- The bills currently define "non-participating" as being out-of-network only. Not all providers who are out-of-network submit claims to an insurer and those that operate outside of insurance, such as direct primary care physicians, should be excluded from any proposal.
- Surprise billing is a surprise because of the lack of transparent pricing. The provider should provide a good faith estimate at least 48 hours prior to a scheduled procedure and an itemized list of charges within 15 business days after discharge. Failure to do so would result in forfeiture of payment.
- In the event of a dispute, arbitration should be voluntary and triggered by the provider if their submitted charges are greater than 3 times of the prevailing Medicare rates. Provider charges are not capped, nor are they tied to Medicare reimbursement, but the 3x factor Medicare serves as a threshold for the purposes of arbitration.
- In the event of a dispute, submitted charges below 3 times prevailing Medicare rates may trigger arbitration by the insurer. If arbitration is not triggered within 15 business days, the insurer shall pay the provider according to the submitted claim within 30 business days.
- The party that triggers arbitration shall be responsible for the cost of said arbitration.
- Consideration for the arbiters shall include historical voluntary payments made by the insurer 3 years prior to the law being enacted and/or use of independent databases such as Fair Health, whichever is greater.
- Upon decision from arbiter, payment must be made within 30 business days.

By following these principles, Congress can ensure insurance companies and doctors have an equal seat at the bargaining table.

The 2.1-million-member *Association of Mature American Citizens (AMAC)*[www.amac.us] is a vibrant, vital senior advocacy organization that takes its marching orders from its members. AMAC acts and speaks on members' behalf, protecting their interests and offering a practical insight on how to best solve the problems they face today. AMAC Action is a 501(c)(4) nonprofit advocacy organization created to assist AMAC members with grassroots participation on Capitol Hill and at the local level through our advocacy programs.