**OHIO STATE MEDICAL ASSOCIATION HOUSE OF DELEGATES**

**Resolution No. 19 – 2020**

**Introduced by:** OSMA District Two

**Subject:** Out-of-Network Billing

**Referred to:** Resolutions Committee No. 2

**- - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - - -**

**WHEREAS**, Many patients receive care from physicians who are not in their insurance company’s restrictive network for multiple reasons; and

**WHEREAS**, This leads to out-of-network bills that are unexpected both to patients and physicians, especially in Emergency situations; and

**WHEREAS**, There are multiple potential legislative solutions being considered both at the national and state levels to address this problem; and

**WHEREAS**, Our AMA has an extensive policy addressing this issue, asking for mediation or dispute resolution mechanisms only in selected instances; **therefore be it**

**RESOLVED**, That the OSMA rescind Policy 19 – 2010 (Lifting the Restrictions on

Balance Billing):

1. The OSMA supports repeal of regulations currently in place that prohibit balance billing for physicians.; and, **be it further**

**RESOLVED**, That the OSMA adopt its own policy similar to AMA policy H-285.904, to read as follows:

1. The OSMA adopts the following principles related to unanticipated out-of-network care:

A. Patients must not be financially penalized for receiving unanticipated care from an out-of-network provider.

B. Insurers must meet appropriate network adequacy standards that include

Adequate patient access to care, including access to hospital-based physician specialties. OHIO regulators should enforce such standards through active regulation of health insurance company plans.

C. Insurers must be transparent and proactive in informing enrollees about all deductibles, copayments and other out-of-pocket costs that enrollees may incur.

D. Prior to scheduled procedures, insurers must provide enrollees with reasonable and timely access to in-network physicians.

E. Patients who are seeking emergency care should be protected under the “prudent layperson” legal standard as established in state and federal law, without regard to prior authorization or retrospective denial for services after emergency care is rendered.

F. Out-of-network payments must not be based on a contrived percentage of the Medicare rate or rates determined by the insurance company.

G. Minimum coverage standards for unanticipated out-of-network services should be identified. Minimum coverage standards should pay out-of-network providers at the usual and customary out-of-network charges for services, with the definition of usual and customary based upon a percentile of all out-of-network charges for the particular health care service performed by a provider in the same or similar specialty and provided in the same geographical area as reported by a benchmarking database. Such a benchmarking database must be independently recognized and verifiable, completely transparent, independent of the control of either payers or providers and maintained by a non-profit organization. The non-profit organization shall not be affiliated with an insurer, a municipal cooperative health benefit plan or health management organization.

H. Mediation and/or Independent Dispute Resolution (IDR) should be permitted in all circumstances as an option or alternative to come to payment resolution between insurers and providers.

2. The OSMA will advocate for the principles delineated in THIS POLICY for all health plans, including ERISA plans.

3. The OSMA will advocate that any legislation addressing surprise out of network medical bills use an independent, non-conflicted database of commercial charges; and, **be it further**

**RESOLVED**, That the OSMA’s delegation to our AMA submit a resolution at A-20 asking for this amendment to Item H in their policy.

**Fiscal Note:** $ 10,000 (Sponsor)

$ 10,000 (Staff)