

Eliminate Surprise Billing

Lower health care costs for consumers

The cost of health care in the United States continues to rise, with health care spending now expected to exceed \$3.8 trillion in 2019 and reach \$5.7 trillion by 2026. Additionally, per capita spending is at its highest level in history, exceeding an average of \$11,000 annually. Health care costs for families have doubled over the last decade and nearly 80% of Americans are dissatisfied with the cost of health care. A meaningful opportunity to address these affordability challenges and improve patient experience is to eliminate Surprise Billing.

Balance Billing occurs when a patient is billed by a provider or facility for amounts beyond what their insurer will cover for out-of-network services. Surprise Billing – a type of Balance Billing – frequently occurs when patients receive out-of-network care from an in-network facility or when they receive emergency services at an out-of-network Emergency Department (ED). Eliminating Surprise Billing will reduce consumers' out-of-pocket costs and premiums, lower health care costs for employers, States, and taxpayers, and will facilitate movement toward a consumer-centric health care system.

Protect Consumers from Surprise Billing

Some States have enacted legislation to protect consumers from Surprise Bills, with policies that prohibit Surprise Billing by providers and establish a benchmark rate and/or a dispute resolution process for both emergency services and out-of-network services at in-network facilities. These State laws generally provide protections to consumers in insured products, but to date, most States have not extended Surprise Billing protections to residents who are enrolled in self-funded plans – a common coverage model for large employers – that are governed under Federal ERISA statutes. A combination of State and Federal actions are needed to end Surprise Billing and protect all consumers from high Surprise Bills. Comprehensive Surprise Billing reforms should achieve all of the following:

- Eliminate Surprise Bills by care providers when patients receive emergency services at an out-of-network facility, or when they receive care from an out-of-network provider at an in-network facility, including bills from lab and durable medical equipment (DME) providers.
- Cap consumer out-of-pocket costs at the same level as in-network cost-sharing.
- Increase consumer transparency – by requiring hospitals to notify consumers when any treating provider is out-of-network – and provide reasonable options to patients to receive in-network care for non-emergent services.
- Establish a benchmark rate to determine the amount the insurer or health plan owes the provider, facility, lab, or DME supplier that is fair, predictable, administratively simple, and does not create incentives for providers to remain out-of-network.
 - Use either a rate indexed to Medicare or the median contracted rate in a defined geography as the benchmark rate.
- Disallow out-of-network facilities from charging additional facility fees to insurers to make up for lost Surprise Billing revenues.
- Provide Surprise Billing protections for enrollees in fully insured products, as well as in self-insured products through a combination of State and Federal legislative actions.



Nearly 1 in 3 adults

having trouble paying medical bills say the problem stemmed from surprise out-of-network care, according to a 2016 report on surprise medical bills



1 in 5 ER patients

are treated by out-of-network physicians at in-network facilities



Out-of-network emergency department physicians charge

on average, 637%, of what Medicare pays for the same services, and 2.4 times more than in-network commercial rates