COMMITTEE ON
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the WAY FORWARD *on* HEALTH CARE

PUTTING AN END TO SURPRISE MEDICAL BILLING

What's the problem?

Emergencies happen. And when they do, families don't have time to pull up Google Maps and find out how close the nearest in-network emergency room is.

Because of this, many privately insured Americans who find themselves at an out-of-network emergency room or have to be treated unexpectedly by an out-of-network provider later receive significant medical bills.

These "surprises" occur for two reasons: first, because the insurance company and the provider are unable to come to an agreement on the provider's compensation for services; and second, the patient has no idea the cost or network status of their provider.

Here's how we'd fix it:

These provisions are all included in the bipartisan Consumer Protections Against Surprise Medical Bills Act of 2020.

End Surprise Medical Bills. Providers (including facilities) will be prohibited from balance billing patients for surprise services. Patients cannot be charged more than the in-network cost-sharing amount.

Create New Patient Protections. Patients will receive an Advance Explanation of Benefits — a true and honest cost estimate — that describes which providers will deliver their treatment, the cost of services, and provider network status. Patients will also see additional relief from surprise bills, and those undergoing treatment at the time their provider leaves their network will receive an up to 90-day period for transitioning care.

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Allow for a Mediated Dispute Resolution Process. In most cases, plans and providers will resolve payment issues without federal intervention. However, when the requested or proposed payment amount is unsatisfactory, a two-step process is available to resolve disputes. This process respects the rights of private parties to freely contract and negotiate. There is no minimum dollar threshold to bring disputes, and the Secretary of the Department of Health and Human Services (HHS) is permitted to develop a process that would allow batching of similar claims if it would promote efficiency. First, either party may initiate an open negotiation process – a 30-day period that allows the private parties to attempt resolution and requires the exchange of certain information. If the parties do not reach resolution, either can initiate the mediation process, administered by independent third parties without any affiliation to providers or payers. The independent third parties will be assigned or selected through an impartial process, subject to rules determined by the relevant Secretary. During mediation, the parties will present best and final offers along with any supporting information to the mediator, who will also consider the median contracted rate specific to the plan, and for similar providers, services, and geographic areas. Independent entities are prohibited from considering usual and customary charges or billed charges, and other guardrails ensure a fair and reasonable process.

Help the Uninsured or Those Paying Cash. For individuals without health insurance or electing to pay cash, providers will share cost estimates directly with patients before a procedure. If the final charge is significantly higher than the cost estimate, the final payment will be determined through mediation.