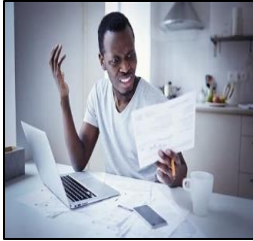


States Should Act Now to Protect Patients from Surprise Billing



When a patient goes to an in-network hospital but gets an outrageous bill from an out-of-network provider for the visit or procedure, this is commonly referred to as a surprise medical bill. Surprise bills can also stem from out-of-network emergency rooms where the patient has little to no choice in choosing providers and when patients are transferred from an in-network facility to somewhere else. Surprise bills are unfair and harm patients. The practice has become a common business model used by some private equity firms to cash in on their provider group or hospital investments. Patients deserve better.

States Need to Do Better With Surprise Medical Billing Legislation

Some states such as Michigan and California are leading the way in combatting surprise medical billing, but many other states have taken little to no action to protect patients from these unfair and abusive medical bills. No federal law currently limits this practice, but as of October 2020, 32 states have enacted laws to protect patients. Some of these states have done great work, but only 16 of the 32 states provide comprehensive balance billing protections for patients. Eighteen states plus D.C. do not have any meaningful protections against surprise billing. It is time for these states to catch up.

Some states have made the situation even worse by preserving the irresponsible out-of-network surprise billing strategies of certain physicians and other health care providers. These state laws force insurance companies to pay providers' "billed charges" – a fake and often outrageous price tag, invented by providers, for how much they would like to be paid. Often this happens under the guide of mandatory "arbitration." As a result, patients suffer higher health care costs. These states should reverse course.

How States Should Eliminate Surprise Medical Bill

Two simple policy changes could eliminate most surprise medical bills, without increasing health care costs for patients, and without causing financial instability to providers:

- ***In-Network Matching Rate Guarantee***: If a physician or other health care provider elects to practice at an in-network facility, the provider should accept the in-network rate at the facility; *and*

- ***Market-Based Default Rates For Emergency Care at an Out-of-Network Facility***: If a patient needs emergency care, and the care they receive is at an out-of-network facility, policymakers can base insurer payments on a benchmark rate, such as the median in-network provider rate or a multiple of Medicare rates. We suggest using 125% of Medicare rates, or considering a market-based rate such as the median contracted in-network rate for the same or similar services agreed to between plans and providers in a specified market or geography.



These solutions will allow a patient to be held harmless, owing only their normal in-network copays and deductibles. At the same time, they guarantee that providers are paid based on actual market conditions, with rates freely negotiated and agreed to by other providers for the same services, in the same geographic area. This is not "big government" or "rate-setting" – it is **fixing a market failure** that has allowed this problem to develop and fester.

The Time to Act is Now

States can end surprise medical billing for more than 100 million Americans who are in state-regulated health plans. But they need to act now and resist the health industry actors seeking to enshrine surprise billing with fake "solutions" that will increase costs and hurt patients.

