



# Protect Consumers from Surprise Medical Bills, Prevent Unsustainable Cost Growth

**Surprise medical bills reflect the breakdown of truth, transparency, and fairness in the healthcare system. Patient must be protected from surprise medical bills today and from unaffordable healthcare in the future.**

## Surprise medical bills pose a well-documented and immediate threat to all patients.

Also known as out-of-network balance billing, surprise billing occurs when an insured patient, through no fault of their own, is treated by an out-of-network provider, and then is charged the difference between the rate their insurer pays the provider and the provider's billed charge. This amount is often many times what the consumer's in-network cost-sharing responsibility would be. Consumers who have health insurance, frequently a large cost itself, should not have their personal finances threatened by out-of-network care that is out of the patient's control. And yet, for millions of patients a year, that is the current reality. Legislation that takes consumers out from the middle of billing disputes, and which applies to all forms of coverage, is the only solution.

## The solution to surprise medical bills must not further inflate out-of-control healthcare costs.

The default payment level should be set with a view toward maintaining affordability of premiums and

insurance coverage. When coverage is not affordable, healthcare is not accessible.

Consumers have a very strong interest in assuring payment rates for surprise bills do not result in excessive charges that get passed along as higher insurance premiums. When health insurance becomes more expensive, fewer consumers can afford it, and some decline to enroll. Others are forced to enroll in high deductible plans; and finally others are negatively impacted because they must draw from their family income and resources to pay for coverage, expending their budget for goods and necessities.

Whether the solution to surprise medical bills fans the rapid and unsustainable growth in healthcare costs will come down to how default payments for out-of-network providers is set.

## Getting the details right is as important as choosing the right reimbursement method.

1. Non-negotiated billed rates – i.e. out-of-network claims – should not be adopted as a criteria for default rates for surprise medical bills.
2. Provider compensation should be based on local median contracted rates, which have been negotiated.
3. When standardizing the methodology for calculating a benchmark rate, input from stakeholders (i.e. insurers, providers, and consumer advocates) can help reach a reasonable balance.

## The options boil down to:

- 1 Benchmark payments that reimburse providers at a specified, predictable rate.
- 2 Arbitration model that typically allows providers and health plans to submit to arbiters a rate that they consider reasonable. The arbiter decides based on criteria specified in the law.

**Benchmark payment is the best option for fairly compensating providers while keeping healthcare affordable in the future.**

### BENCHMARK REIMBURSEMENT

- Payment based on a standardized calculation provides **greater clarity and administrative simplicity.**
- Payment to providers based on rates already negotiated by peers.
- Reimbursement calculation can account for, and appropriately compensate, higher-complexity cases.
- **Benchmark reimbursement works.** In California<sup>1</sup>, the default is benchmark reimbursement with an optional independent dispute resolution process (IDRP). The California Department of Managed Health Care (DMHC) oversees plans that provide coverage to more than 26 million Californians<sup>2</sup> and is one of two regulators that enforces the state's SMB law. Despite the number of potential billing disputes, there were only 68 applications for IDRP. Of those, 45 were withdrawn or ineligible, 20 were pending as of July 2019, and 3 were decided, all in favor of the health plan.<sup>3</sup>
- Congressional Budget Office (CBO) estimates that benchmark rate setting in the Senate HELP Committee bill would reduce insurance premiums by about 1 percent and decrease deficits by \$25 billion over ten years.<sup>4</sup>

### ARBITRATION MODEL

- Highly dependent on the specific details of how offers would be made, and criteria for evaluation
- Could incentivize some providers to stay outside of health plan networks, undermining affordability and continuity of care for patients.
- Would likely create **significant additional administrative expenses** and **slow the reimbursement process**; and **instill complexity, confusion**, when there is a fair and straightforward alternative.
- Potentially drives-up costs for consumers, employers, and health plans and insurers; relatedly, could drive-up health insurance premiums and associated costs of coverage.<sup>5</sup>
- CBO estimates that allowing for arbitration in the House Energy and Commerce SMB legislation would eliminate 25% of potential savings.<sup>6</sup>

<sup>1</sup> California bill AB 72 passed in 2017. For an analysis of the outcome of AB 72, see Duffy, Erin L, PhD MPH, "Influence of Out-of-Network Payment Standards on Insurer-Provider Bargaining: California's Experience," (August 5, 2019).

<sup>2</sup> The Department of Managed Health Care fact sheet, available at [http://dmhc.ca.gov/Portals/0/Docs/DO/2018Infographic\\_accessible.pdf](http://dmhc.ca.gov/Portals/0/Docs/DO/2018Infographic_accessible.pdf).

<sup>3</sup> These results reflect the period between September 1, 2017 and July 19, 2019. "AB 72: Stopping Surprise Bills from Out-of-Network Doctors at In-Network Facilities," Health Access

and California Labor Federation fact sheet (July 22, 2019). Available at [https://health-access.org/wp-content/uploads/2019/07/AB-72-Fact-Sheet\\_updated-7.22.19.pdf](https://health-access.org/wp-content/uploads/2019/07/AB-72-Fact-Sheet_updated-7.22.19.pdf)

<sup>4</sup> Congressional Budget Office, "S. 1895, as ordered reported by the Senate Committee on Health, Education, Labor, and Pensions," (July 16, 2019).

<sup>5</sup> The arbitration criteria preferred by some specialty providers – using billed charges as a basis for setting payment – would inflate costs throughout the system, ultimately raising premiums for consumers. Especially if billed charges are used

as criteria in the arbitration process, excessive charges for medical services would be passed along to patients in the form of higher premiums.

<sup>6</sup> Congressional Budget Office, Cost Estimate: H.R. 2328, Reauthorizing and Extending America's Community Health Act As ordered reported by the House Committee on Energy and Commerce on July 17, 2019, (September 18, 2019).