

STANDING TOGETHER FOR PATIENTS: PROTECTING AMERICANS FROM SURPRISE MEDICAL BILLS

Everyone in America deserves affordable, high-quality coverage and care, and control over their health care choices. Surprise medical bills undermine these values, putting the health and financial stability of millions of patients at risk every year. As organizations representing America's consumers, businesses, and health insurance providers, we all have a role to play in ensuring that patients are informed, engaged, and protected from excessive costs for the care they need. We agree on the following principles to best ensure that patients can get the care they need at costs they can afford:

- **Patients Should be Protected from Surprise Medical Bills.** We support federal legislative action to end surprise medical bills. Often, patients are treated in an emergency department that does not participate in their insurance network or by a specialist who does not participate, despite being at an in-network facility or doing all they can to ensure they are being treated in-network. Patients should not be financially penalized in cases when they receive out-of-network care through no fault of their own. In these circumstances, providers should be prohibited by law from billing the patient for costs not covered by their health plan.
- **Patients Should Be Informed When Care Is Out of Network.** Patients have a right to know about the costs of their treatment and options. They should receive complete information about whether facilities or providers do not participate in the patient's health plan and what that could mean for the patient's financial obligations. Patients should receive a notice that is meaningful, timely, specific, and in plain language. This disclosure should provide patients with a meaningful opportunity to seek in-network care and an estimate of the costs of out-of-network care.
- **Federal Policy Should Protect Consumers from Surprise Medical Bills While Restraining Costs and Ensuring Quality Networks.** Putting patients first means enacting policies that protect consumers from surprise bills while ensuring that such policies do not simultaneously increase premiums or other costs for consumers, or disincentivize network participation. Policy should encourage health plans and providers to collaborate by building networks that deliver high quality care and value. Federal policy should focus on ensuring that providers are fairly compensated for their services, while encouraging them to participate in high-value provider networks. Policies that excessively pay out-of-network doctors raise premiums for everyone, undermine networks and care coordination - increasing health care and coverage costs while decreasing value for patients. In setting a standard, Congress should ensure that the method does not lead to increased health costs for either the individual consumer or the health care system.
- **Payments to Out-of-Network Facilities and Doctors Regarding Surprise Billing Should be Based on a Federal Standard.** More than 100 million Americans are enrolled in self-funded health plans, and protecting those consumers requires federal action that reduces complexity while ensuring they cannot be surprise billed. Any federal standard for out-of-network payments should allow state flexibility for fully insured plans so long as a minimum federal threshold is achieved, but preserve ERISA's national, uniform rules for self-funded plans. Any federal standard for payments to out-of-network doctors should apply to self-funded ERISA health plans, as well as in states that don't enact their own standards for fully insured plans.

Accidents and illnesses happen, and no medical emergency should break the bank. By working together in accordance with these principles, we can ensure that every patient has the peace of mind that comes with knowing that they are able to get the best possible care, value, and personal control over their own well-being.