



Protecting Patients from Surprise Medical Bills

Key Points:

- No American should delay care or face financial ruin because of surprise medical bills.
- The Committees on Energy and Commerce, Ways and Means, and Education and Labor have collaborated over several years to find a bipartisan path forward to end surprise medical bills.
- This bipartisan, bicameral agreement is a free-market solution that takes patients out of the middle and fairly resolves payment disputes between plans and providers.

The real-world impact of surprise medical bills:

Drew Calver, a teacher from Texas, was rushed to an out-of-network hospital when he had a heart attack. Afterwards, he was hit with a surprise bill of \$108,951.

Sonji Wilkes gave birth at an in-network facility and her son was sent to the NICU for treatment. However, the NICU was not in-network and Wilkes and her family received a \$50,000 bill.

Elizabeth Moreno had back surgery and was prescribed an opioid; a routine follow-up drug test resulted in a \$17,850 bill.

What the agreement does:

- Protects patients from surprise bills.
- Ensures physicians and other health workers don't face economic harm and uncertainty.
- Protects **all** stakeholders, most importantly patients, while also ensuring a pathway for resolution of payment disputes for health care services that are consistent with private market practices.
- Empowers consumers by providing a true and honest cost estimate that describes which providers will deliver their treatment, the personalized cost of services, and provider network status.

What the agreement does not do:

- This text includes **NO** benchmarking or rate-setting.
- This doesn't increase premiums for patients or interfere with any strong, state-level solutions already on the books.

How it works:

- First and foremost, patients are protected from surprise medical bills – under this agreement, they don't have to pay any more than their in-network cost sharing.
- If a health care provider is not satisfied with the payment they receive, they can initiate an open negotiation period and, if no resolution is reached, can pursue a dispute resolution process where an independent arbitrator considers relevant factors and determines a fair payment.
- This independent dispute resolution process fairly decides an appropriate payment for services based on the facts and relevant data of each case. This results in savings by stopping bad actors from driving up costs across the health care system, and those savings will be reinvested in important priorities like community health centers.
- There is no dollar amount threshold to enter the open negotiation and independent dispute resolution processes– all claims will be eligible.
- The arbitrator must equally consider many factors, including:
 - Median contracted rates;
 - Education and experience of providers and severity of individual cases;
 - Previously contracted rates going back four years;
 - Good faith efforts to negotiate – bad actors will be held accountable;
 - Market share of both parties – this will help prevent any stakeholder that dominates a region from trying to set rates at an untenable level; and
 - Any other factors brought forward by providers and plans, except for billed charges or government-set rates.