LOWER HEALTH CARE COSTS ACT OF 2019

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#LOWERHEALTHCARECOSTS

The Truth about Surprise Medical Billing

20% of emergency room visits result in patients receiving a surprise medical bill because they see a doctor they did not choose: either because of emergency care at an out-of-network hospital, or because an out-of-network doctor, not chosen by the patient, treats them at an in-network hospital. A surprise medical bill is one of the most important problems for the 200 million Americans who have insurance on the job or in the individual market – and it is a problem caused by 5% of doctors at 10% of hospitals.

The Lower Health Care Costs Act of 2019 would ensure that patients do not receive a surprise medical bill.

Here's how: insurance companies would pay out-of-network providers the local, market-driven rate — which would be the same local market-based rate that insurers negotiated with providers who agreed to be in-network.

- The Lower Health Care Costs Act does not allow the federal government to set rates. The market will set a benchmark that reflects the cost of providing care in that area.
- The benchmark would only apply in very limited scenarios since 5% of doctors at 10% of hospitals, backed by private equity firms, send the majority of surprise medical bills to patients.
- The Congressional Budget Office estimates the "benchmark" approach for ending surprise medical bills will save taxpayers $25 billion over the next ten years.

Some believe that the federal government should establish a new nationwide third-party arbitration system to settle billing disputes between insurers and providers. Relying on local markets, rather than government officials negotiating a patient's medical bill, is a more effective way to solve a market failure.

Ben Ippolito, American Enterprise Institute: "If patients cannot reliably avoid providers who engage in such practices, they cannot send market signals to end it. Because of this market failure, targeted legislative intervention is well merited."

Chris Pope, Manhattan Institute: "Ending the right of providers to fill in a blank check for emergency medical procedures would directly help some of the most vulnerable patients, who are being subject to exorbitant bills… A cap limited to out-of-network fees for emergency care could hardly be more different in spirit from proposed single payer or all-payer reforms, which propose to effectively set a comprehensive floor on payment rates for all medical services—elective as well as emergency; in-network as well of out-of-network… Providers could still insist on their preferred reimbursement arrangements before agreeing to deliver elective care, and insurers could still negotiate discounts from preferred networks of providers."

Avik Roy, writing in Forbes: "If we do nothing [to address surprise medical bills], the problem will get far worse. If we do something that is too incremental, we'll pat ourselves on the back and then be forced to revisit the problem in a few years. Americans deserve market-based alternatives to single-payer health care. Without reform of exploitative hospital prices, we'll never get there."