[illegible] of-network doctors can submit bills up to nearly 100 times higher than the fees paid by Medicare for the same service.[4] These balance bills have significant financial ramifications for consumers and patients. Patients enrolled in Health Maintenance Organizations (HMOs) and Exclusive Provider Organizations (EPOs) would likely be responsible for the cost of these services in their entirety, as these plans typically place restrictions on out-of-network care except in an emergency. While Preferred Provider Organizations (PPOs) and Point-of-Service (POS) plans customarily provide out-of-network coverage, they typically pay a smaller portion of the billed charges. The non-negotiated rates for PPOs and POS are usually higher than those allowed or recognized by the payor. Therefore, patients in plans with out-of-network coverage provisions are often held liable for the balance above and beyond what their plan pays, in addition to being subject to greater levels of cost-sharing on covered benefits or services.

There is a financial incentive for consumers to use in-network services as they are more affordable. As such, many patients do their due diligence to select in-network providers and facilities to avoid incurring higher out-of-pocket costs. However, unlike pre-planned or scheduled visits to providers, situations involving hospital-based care, or facility-based care can be tricky, or sometimes near impossible, to navigate. Surprise balance bills can arise from emergency or urgent situations when the patient has no ability to select the treatment or care facility, physicians or care team, ancillary providers, or ambulance service or medical transport company. For example, air ambulances provide emergency transport fQq0.00000912 0 612 792 reW*nBT/F2 11.04 Tf1 0 0 1 487.42 475.03 9.91 Tm0 g0 G)]T6(c)-3(a)3(re)5( )3

in which they work. Of the in-network hospitals for the three Texas insurers with the largest market share, between 21% and 45% had no in-network emergency room physicians.[8]

Despite its pervasiveness, many consumers are not aware of the prospect of a surprise balance bill until they receive one. More than 60% of respondents in a national Consumer Reports survey mistakenly assumed that if they went to an in-network hospital, all the doctors at the hospital would also be in-

that provide coverage in connection with those plans, are required to treat out-of-network emergency services as if they were delivered at an in-[illegible] amounts. While the federal provisions do not prevent out-of-network providers from balance billing patients for the amount their plan does not cover, they do attempt to limit the financial exposure for patients who are treated by an out-of-network provider for emergency services. This is done through a federal payment methodology that ensures a plan or issuer does not pay an unreasonably low amount to an out-of-network provider who, in turn, will simply balance bill the patient.

In Medicare, beneficiaries are fairly insulated from balance billing and surprise medical bills, as physicians who participate in Medicare may not balance bill for any amount beyond the standard Medicare cost-sharing. Even non-participating providers- which only account for about 4% of practitioners registered with Medicare- are limited in the amount they can balance bill beneficiaries to 115% of the Medicare Physician Fee Schedule.

Quality, affordable health care is a key advocacy priority for the AHA and represents a significant concern for the patients we represent. As an organization, we have long supported efforts that empower consumers to make informed health care decisions but recognize that strategies aimed at addressing surprise balance bills must equip patients with the adequate tools and information in order to do so. Because the practice of surprise balance billing insured patients is particularly perverse and objectionable- threatening the financial security and livelihood of Americans across the country and limiting their ability to get the care they need when and where they need it - the AHA believes policymakers, in conjunction with public and private stakeholders, must take a multi-faceted approach to comprehensively address balance billing. To that end, we have developed a set of principles to frame our advocacy in support of patient-centered and consumer-focused protections from surprise balance bills.

Patients and consumers should be held harmless from balance bills in situations that arise from emergencies (including emergency ground or air transportation and transfers) and instances where an insured patient visits an in-network facility for a covered service, but unknowingly receives care from an out-of-network provider. In circumstances where a