Delaware Healthcare Association Principles on "Surprise Billing"

1. **Define "surprise bills."** Surprise bills typically refer to situations where: (1) a patient accesses emergency services outside of their insurance network, including from providers while they are away from home; (2) a patient receives care from an out-of-network physician providing services in an in-network hospital; or (3) a health plan denies coverage for emergency services saying they were unnecessary.

2. **Protect the patient financially**. Patients should have certainty regarding their cost-sharing obligations, which should be based on an in-network amount. Patients should not be balance billed (should not receive a bill beyond their cost-sharing obligations). Patients should not have to bear the burden of serving as an intermediary between health plans and providers. Instead, health plans should be responsible for paying providers directly.

3. **Ensure patient access to emergency care**. Patients should be assured of access to and coverage of emergency care. This requires that health plans adhere to the "prudent layperson standard" and not deny payment for emergency care that, in retrospect, the health plan determined was not an emergency.

4. **Preserve the role of private negotiation**. Health plans and providers should retain the ability to negotiate appropriate payment rates. The government should not establish a fixed payment amount or reimbursement methodology for out-of-network services, which could create unintended consequences for patients by disrupting incentives for health plans to create comprehensive networks. Hospitals and insurers should continue to negotiate reimbursement for out-of-network claims, with an independent dispute resolution process serving as a backstop for unresolved disputes.

5. **Remove the patient from health plan/provider negotiations**. Patients should not be placed in the middle of negotiations between insurers and providers. Health plans must work directly with providers on reimbursement, and the patient should not be responsible for transmitting any payment between the plan and the provider.

6. **Educate patients about their health care coverage**. All stakeholders – health plans, employers, providers and others – should undertake efforts to improve patients' health care literacy and support them in navigating the health care system and their coverage.

7. **Ensure patients have access to comprehensive provider networks and accurate network information**. Health plans should provide easily-understandable information about their provider network, including accurate listings for hospital-based physicians, so that patients can make informed health care decisions. Regulators should ensure the adequacy of health plan provider networks and accuracy of provider directories.

8. **Support state laws that work**. Any federal solution should provide a default to state laws that meet the federal minimum for consumer protections.

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