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**THA Federal Priority: Surprise Billing**

*Updated October 2020*

**Why this is important**

Surprise medical billing may occur when a patient receives care from an out-of-network provider or physician, in many instances during an episode of care with an in-network hospital, or when their health plan fails to pay for covered services.

**Key talking points**

* Whether due to insurance coverage gaps, or other failures in the healthcare system, no patient should have to worry about unanticipated medical bills when dealing with a health crisis.
* All Stakeholders – health plans, employers, providers, and others – must do a better job of educating patients about their health care coverage.
* Patients should have access to comprehensive provider networks and accurate network information.
* Health plans should have the primary obligation to bring specialty physicians into network and negotiate with them in good faith.
* Any proposal to help take the patient out of the process should NOT include rate setting and SHOULD include an independent arbitration process between providers and payers to resolve disputed charges.

**Background**

Throughout early last year, Congressional hearings were held and various bills were introduced advocating for different solutions, essentially using either an arbitration or a benchmark pre-determined reimbursement rate, or some combination of the two. By February 2020, most members of Congress had decided in favor of one of two major legislative approaches.

* Senate HELP Committee Chairman Lamar Alexander (R-TN) and House Energy and Commerce Committee Chairman Frank Pallone (D-NJ) and Ranking Member Greg Walden (R-OR) in December agreed to a combined surprise billing proposal which includes details from the previous bills their committees passed last year.
  + Would set benchmark rates for out-of-network providers at the median of in-network contracted rates for the geographic area. It includes arbitration as a fallback option which providers or insurers may elect if the median in-network rate payment exceeds $750.
  + **THA position**. THA, the AHA and other provider organizations strongly oppose this model.
* The House Ways and Means Committee in February unveiled their proposal, which relies primarily on arbitration to resolve disputed charges. This proposal would provide a two-step process, initially requiring providers and insurers to negotiate for a limited period and exchange certain information, including the insurer’s median in-network rate and the provider’s median reimbursement for the same service.
  + No minimum dollar threshold to bring disputes and HHS may develop guidelines to allow for batching of similar claims to promote efficiency. If a payment agreement is not reached through negotiations, either party can seek resolution through a mediated dispute resolution process. The mediators would be independent third parties subject to rules outlined by the HHS secretary and mediators may consider the median contracted rate for similar providers, in a similar geographic area, for a similar service. Usual and customary charges or billed charges may not be considered. The party who loses the decision pays the mediation process fees.
  + **THA position**. Preferred over HELP/E&C approach because of the arbitration provision.

**Current state**

The issue has begun to be more visible once again. Language was included in the Terms and Conditions for CARES Act Provide Relief Fund payments, which prohibits surprise billing for COVID-19 care. A larger ban on surprise billing on all care, not just limited to COVID-19 care, has been discussed for inclusion in the next stimulus relief bill. These discussions appear to be a straight ban on surprise billing, but no benchmark rate setting or arbitration requirements.

**THA Position**: A ban on surprise billing with no additional requirements is cautiously being viewed favorably by providers.