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SURPRISE! Along with COVID Relief, Congress Delivers Long-Anticipated Changes to Medical Billing with the "No Surprises Act

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On December 21, Congress passed the $900 billion spending and COVID-19 relief package — the Consolidated Appropriations Act, 2021 (CAA) — which President Trump signed on December 27. Although the CAA's monetary relief provisions aimed at helping individuals and small businesses stave off the financial strain of the COVID pandemic have taken center stage, the CAA also includes other headline-worthy legislation. Specifically, the CAA includes the long-anticipated No Surprises Act (Act), which has significant implications for medical providers, payors, and patients. Set to go into effect in 2022, the Act prohibits billing patients for certain out-of-network medical expenses and instead shifts the burden of those expenses to payors and providers. The Act also establishes a dispute-resolution framework for disagreements between medical providers and payors over payment rates for out-of-network services. Below find a high-level summary of the Act and its practical implications for payors, providers, and patients.

Scope of Protection

For years, Congress talked about passing legislation that would reduce the financial burden on patients who receive emergency medical treatment in an out-of-network setting. Under standard billing procedures, when out-of-network medical services are rendered, the payor pays the out-of-network benefit, with the uncovered cost then balance billed to the patient. Congress long lamented that patients find themselves surprised by the cost of care and their responsibility to pay for it. The Act will remove this "surprise" in three primary situations.

First, patients who receive emergency care services from out-of-network providers are only subject to in-network cost-sharing payments (*i.e.,* deductibles and copayments) for screening and stabilization of their condition. Patients cannot be balance billed for the difference between their benefits payments and the provider's billed charges. This means that regardless of where a patient receives emergency care, the patient's out-of-pocket costs will be the same.

Second, the Act extends similar rules to air ambulance medical bills, which often account for some of the largest emergency medical care expenses. When the Act takes effect, patients will bear responsibility only for their in-network cost-sharing amount. Notably, the Act does not extend this rule to ground ambulances.

Third, the Act also addresses situations in which a patient receives nonemergency medical treatment at an in-network facility but performed by an out-of-network provider. A common example of this occurs when a patient

undergoes surgery at an in-network hospital, but the anesthesia is provided by an out-of-network provider. In these situations, the Act creates a default rule that the patient may only incur charges for the in-network cost-sharing fees and cannot be balance billed for any additional costs not covered by the payor.

However, the Act allows limited exceptions to this third scenario, permitting some out-of-network providers to balance bill their patients if the provider, at least 72 hours prior to treatment, (1) gives the patient notice of their network status, as well as estimated charges and (2) obtains patient consent. But this exception for informed consent is narrow. It applies only in nonemergency circumstances. And, it is completely unavailable to many types of providers, including anesthesiologists, radiologists, pathologists, and assistant surgeons. Even with informed consent, these out-of-network providers may not balance bill their patients.

Dispute Resolution Process

Under the Act, patients can take comfort in knowing that in these out-of-network situations, their out-of-pocket expenses will be limited to their in-network cost sharing responsibility. However, payors and providers are left to figure out who bears responsibility for covering the cost of care. Anticipating the disputes that are sure to arise, the Act provides a framework for the payors and providers to resolve their out-of-network billing disputes.

The framework provides that the parties must first engage in a 30-day open negotiation to effectuate a settlement. If that fails, either party may initiate an independent dispute resolution (IDR) process, administered by an independent arbitrator, with the decision binding on the parties.

Notably, the Act adopts a “baseball-style” arbitration procedure, *i.e.*, an all-or-nothing process in which the arbitrator must choose either the proposal submitted by the payor or the proposal submitted by the provider — with no ability to split the difference. This framework encourages payors and providers to reach their own compromise whenever possible; while the parties have maximum flexibility to bridge the gap, the arbitrator has none.

Where the parties cannot reach resolution and must call upon an arbitrator, the arbitrator must consider, among others, the following factors:

- the median in-network rate;
- the level of training or experience of the provider or facility;
- the market share held by the provider or the payor in the geographic region where the service was provided;
- the acuity of patient;
- the complexity of services provided;
- demonstrations of good faith efforts (or lack thereof) made by the provider or the payor to enter into network agreements; and
- prior contracted rates, if any, between the parties during the previous four plan years.

Importantly, the Act also specifies that the arbitrator may *not* consider the provider's billed charges; nor may the arbitrator consider Medicare or Medicaid payment/reimbursement rates. By imposing these parameters, the Act seeks to balance the interests of both the payors and the providers and to protect against exceedingly high or low payments for care.

The Act also allows multiple cases to be batched together in a single arbitration proceeding as long as the batched cases involve (1) the same provider or facility, (2) the same payor, and (3) treatment of the same or similar medical condition that (4) occurs within a single 30-day period. The losing party will be responsible for paying the fees charged by the IDR entity. If a dispute is settled before any ruling is made, such costs would be split equally. The party that initiated the IDR may not take the same party to the IDR for the same service for 90 days following a decision.

Conclusion

The No Surprises Act brings certainty and stability to patients who receive out-of-network care, while shifting a significant financial burden to payors and providers. The Act encourages payors and providers to privately negotiate appropriate payments for the cost of care by imposing strict arbitration parameters and forcing the losing party to incur the added expense of paying the arbitrator's fees.

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