

*NO SURPRISES ACT*

# Protecting Patients from Surprise Medical Bills



## How Surprise Medical Bills Broke the Bank for Millions of Americans

Every year, nearly 136 million patients visit an emergency department in the United States.<sup>1</sup> Most of these patients assume they will pay less out of pocket by visiting a hospital that is part of their coverage network. The reality for many, however, is quite different.

Far too often, a patient's trip to an in-network emergency department may result in bills totaling thousands of dollars. In fact, millions of patients face surprise medical bills at prices they cannot afford and for care they did not choose – or they did not even know they received in the first place. The consequences are significant: financial stress; fighting a complicated, confusing bureaucracy; harassed by collection agencies; and often legal action for non-payment.

Today, federal law prohibits surprise medical billing – also called “balance billing” – in most circumstances. The *No Surprises Act* removes patients from the middle of abusive surprise billing practices and protects Americans from exorbitant bills from out-of-network providers and private equity firms.

Importantly, the legislation relies on arbitration to settle payment disputes between health care providers and health insurance providers. The way these disputes are resolved impacts how much health care costs for everyone.

Anesthesiologists charge  
**5.8 times** the Medicare rate

Radiologists charge  
**4.5 times** the Medicare rate

Pathologists charge  
**4 times** the Medicare rate

Emergency medicine physicians charge  
**4 times** the Medicare rate

## How Many Are Affected / Concentration in Certain Specialties

At least 1 in 6 patients who have health insurance will receive a surprise medical bill from a provider or specialist who treated them.<sup>2</sup> However, not all doctors or local hospitals are the culprits behind out-of-network charges. The real problem of surprise medical bills tended to be concentrated among certain medical specialties where the providers are likely to (a) charge substantially more than their peers in other specialties and (b) not accept private insurance. Most studies on surprise medical bills have found that these bills were most likely to come from emergency medicine physicians, anesthesiologists, radiologists, and pathologists.<sup>3</sup>

- Anesthesiologists charge, on average, 5.8 times the Medicare reimbursement rate
- Radiologists charge 4.5 times the Medicare rate
- Pathologists charge 4 times Medicare
- Emergency medicine physicians charge 4 times the Medicare rate

Every year, the outrageous out-of-network bills from a subset of specialty physicians result in \$40 billion in additional spending in employer-provided coverage alone.<sup>4</sup>

In many cases, an emergency department itself is part of a patient's health plan network, but the physician staff independently contracts with the department and the providers do not accept insurance. When physicians charge excessive, unreasonable rates and refuse to participate in provider networks that would protect patients from exorbitant costs, the patient is often left footing the bill.

A fundamental market failure gave rise to surprise medical billing as a business strategy. At its root was a lack of financial incentive for some hospital-based providers to earn more participating in health plan networks than they would with the option to balance bill. This meant circumstances where consumers lacked any meaningful choice of health care provider, the *No Surprises Act* addresses this issue by creating financial incentives for those providers to participate in health plan networks.

1 [https://www.cdc.gov/nchs/data/nhamcs/web\\_tables/2015\\_ed\\_web\\_tables.pdf](https://www.cdc.gov/nchs/data/nhamcs/web_tables/2015_ed_web_tables.pdf)

2 <https://stopsurprisebillingnow.com/coalition-statement-on-the-no-surprises-act/>

3 Bai, G., & Anderson, G. F. (2017). Variation in the Ratio of Physician Charges to Medicare Payments by Specialty and Region. *JAMA*, 317(3), and Cooper, Z., & Morton, F. S. (2016). Out-of-Network Emergency-Physician Bills — An Unwelcome Surprise. *New England Journal of Medicine*, 375(20), 1915-1918  
[http://faculty.som.yale.edu/fionascottmorton/documents/NEJM\\_ED.pdf](http://faculty.som.yale.edu/fionascottmorton/documents/NEJM_ED.pdf)

4 <https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2019.00507?journalCode=hlthaff>

# The Role of Provider Networks in Health Insurance

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Health insurance providers rely on networks to ensure patients have access to the care they need from doctors they choose and trust. They negotiate payment rates that fairly and reasonably compensate providers for their services and expertise, increasingly with models that reward doctors for delivering higher value care at lower costs. As a result, when doctors and hospitals join a network, patients have greater confidence that they will be protected from high costs when they get sick or injured, particularly in emergency situations.

However, when a doctor is not part of a plan network—even if they separately contract with a hospital to treat patients there—they can charge much higher rates. Under current law and practice, most states allow doctors to bill patients for any balance that may be outstanding after the health insurance provider pays its share of the costs. These charges become truly problematic for patients when out-of-network providers—who are not bound by contractual, in-network rate agreements with an insurance provider—bill patients for the entire remaining balance.

- **In-network provider:** An in-network provider is a physician, hospital, or other provider with whom the health insurance provider or plan has negotiated a payment amount for their services, usually identified by a billing code.
- **Out-of-network provider:** A health care provider who has no contract with the health insurance provider and is not required to accept a negotiated rate.

With a market failure now addressed, it is time for the market to encourage more network participation so that consumers can access quality care from providers that are in their network of care.

Provider networks have been a mainstay of private health insurance coverage for more than 35 years — providing consumers with access to a broad range of hospitals, physicians, and other providers along with financial incentives for members to obtain medical care within the plan's provider network. By establishing high standards for inclusion in their networks, health insurance providers work to ensure that consumers have access to high-quality, cost-effective care.

Health insurance providers evaluate doctors and hospitals for quality and safety performance before including them in a network. This involves ensuring that facilities and providers

meet patient safety goals and credentialing standards. In fact, performance on quality measures is the key part of criteria used for provider selection and inclusion in a plan's network—including high-value network plans. Health insurance providers periodically reevaluate the qualifications of the providers and their performance within their networks to make sure the consumers' needs are met.

Developing stronger provider networks that ensure patients have access to the care they need from providers they choose is not only a top priority for health insurance providers, but also the law. Most health insurance providers are required by law to meet either federal or state standards for network adequacy, many of which are based on the National Association of Insurance Commissioners' Managed Care Plan Network Adequacy Model Act.<sup>5</sup> Although standards vary between different states, they reflect the common theme that plans must provide options that minimize the distance a patient would have to travel for care. In other words, the law requires that private health plans have robust provider networks and also requires regular verification of their continued compliance.

The *No Surprises Act* is structured in a way that recognizes the important role networks play in consumers health journeys and created financial incentives for providers to participate in health plan networks. By encouraging provider network participation, the *No Surprises Act* gives consumers greater choice over their health care experience and more affordable care through in-network rates.

## Federal and State Regulation of Surprise Medical Billing

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Prior to enactment of the federal *No Surprises Act*, many states had laws to provide some level of protection against surprise bills for residents enrolled in health insurance plans regulated by the state. Under the Employee Retirement Income Security Act of 1974 (ERISA), states may regulate fully insured health insurance plans, but have little to no authority to regulate self-funded health plans, which are governed by ERISA. Of the nearly 180 million Americans enrolled in group health plans provided by an employer, more than 6 in 10 are in self-funded plans.<sup>6</sup> As a result, states were unable protect the more than 100 million Americans in self-funded plans from surprise medical bills.

The *No Surprises Act* became the first federal prohibition on surprise medical billing. Signed into law in December 2020,

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<sup>5</sup> [https://content.naic.org/cjpr\\_topics/topic\\_network\\_adequacy.htm](https://content.naic.org/cjpr_topics/topic_network_adequacy.htm)

<sup>6</sup> <https://www.kff.org/report-section/ehbs-2021-section-10-plan-funding/>

the *No Surprises Act* protects people covered under group and individual health insurance plans from receiving balance bills following health care that includes most emergency services, non-emergency services from out-of-network providers at in-network facilities, and services from out-of-network air ambulance service providers. A consumer's financial obligation in those scenarios is now limited to what the in-network cost-sharing would have been had the provider participated in the patient's health plan

To determine how much the out-of-network provider is to be paid, the *No Surprises Act* establishes an independent dispute resolution (IDR) process and removes the patient from the middle of the dispute. This process provides new dispute resolution opportunities for uninsured and self-pay individuals when they receive a medical bill that is substantially greater than the good faith estimate they received in advance from the provider. Those enrolled in government health programs such as Medicare, Medicaid, and TRICARE are already protected.

## Basic Protections of the *No Surprises Act*

The *No Surprises Act* protections – including transparency requirements and protection from balance billing – apply to plan years beginning January 1, 2022.

- Prohibits surprise bills for most emergency services, even if received out-of-network and without approval beforehand (prior authorization). This includes post-stabilization care.
- Prohibits out-of-network cost-sharing (like out-of-network coinsurance or copayments) for most emergency and some non-emergency services. Consumers cannot be charged more than in-network cost-sharing amounts for these services.
- Bans out-of-network charges and balance bills for certain additional services furnished by out-of-network providers as part of a patient's visit to an in-network hospital or other facility.
- Requires that health care providers and facilities furnish patients with a plain-language notice explaining the applicable billing protections, who to contact if they have concerns that a provider or facility has violated the protections, and that patient consent is required to waive billing protections (i.e., you must receive notice of and consent to being balance billed by an out-of-network provider).

A consumer's cost-sharing will be determined based on what the terms of in-network cost-sharing are for the plan in which they are enrolled. Under the law and its regulations, the determination of in-network cost-sharing will be based on either the recognized amount as set by state law or, for plans governed solely by the *No Surprises Act*, the Qualifying Payment Amount (QPA).

*The QPA is a measure of locally negotiated market rates, defined as the median of all contracts with participating providers in that geographic region for the same or similar item or service.*

## The Role of State Laws

Similar to other federal laws, the *No Surprises Act* supplements existing state law, rather than replacing them. The *No Surprises Act* acts as a "floor" for consumer protections against surprise bills from out-of-network providers and related higher cost-sharing responsibility for patients. If a state law provides at least the same level of consumer protections against receiving a bill or paying higher cost-sharing for a certain service, the state law will continue to apply and govern how payment disputes are to be resolved. However, if a state law provides less protections than the *No Surprises Act*, or the state does not regulate surprise bills, then federal law will apply. The *No Surprises Act* also applies to all ERISA self-funded health plans and to state laws that do not apply to all items or services received during a care visit.

There is significant variation in how state laws resolve out-of-network billing disputes – including states that rely on a benchmark approach and those that utilize independent dispute resolution.

California passed surprise medical billing legislation (AB 72) in 2016. The legislation set a benchmark reimbursement rate for out-of-network providers and, as a result, the number of in-network doctors has increased by 16%.<sup>7</sup>

On the other hand, arbitration has been disastrous for New York patients. Under arbitration models, both insurance providers and care providers submit a proposed dollar amount to government-appointed arbiters, who then choose the final monetary award. The result has been a 300% increase in the price of emergency services claims that have gone to arbitration since the program began.<sup>8</sup>

<sup>7</sup> <https://www.ahip.org/new-study-californias-surprise-medical-bill-legislation-protects-patients-without-threatening-provider-networks/>

<sup>8</sup> New York State Department of Financial Services Reports



## Resolving Payment Disputes through Independent Dispute Resolution

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Once a patient is taken out of the middle, a health insurance provider or health plan that receives a claim from an out-of-network provider will attempt to issue a payment or denial of payment to the out-of-network provider. This initial payment may end the dispute entirely. Alternatively, a provider or facility that believes they are entitled to a higher payment amount may elect to begin an open negotiation process created by the *No Surprises Act*. If, after 30 days of open negotiation between the plan and provider or facility, no mutually agreeable reimbursement amount is determined, a party may elect to pursue IDR.

The *No Surprises Act* requires binding, final-offer IDR (arbitration) in which both parties submit final offers as to the reimbursement amount and a Certified IDR Entity licensed by the U.S. Department of Health and Human Services (HHS) makes a determination. Certified IDR Entities are required to consider the following factors in making a determination:

- The QPA, which is generally the insurer's median in-network rate for similar services in that geographic region as of 2019, inflated forward by the Consumer Price Index for All Urban Consumers (CPI-U);
- Demonstrations of good faith efforts (or lack thereof) to reach a network agreement and any contracted rates between the two parties during the previous four years;
- Market shares of both parties;
- Patient acuity; and
- The level of training, experience, and quality of the clinician, or the teaching status, case mix, and scope of services offered by the facility.

New final regulations on the IDR process are expected in Summer 2022. Under interim final rules issued in October 2021, arbitrators were directed to begin with the presumption that the offer closest to the QPA should prevail. Anchoring IDR decisions to the QPA helps foster predictability, which should reduce administrative costs and discourage unnecessary arbitration, while encouraging network participation, as out-of-network payments will skew towards the median of in-network contracted rates. This regulatory approach benefits consumers by lowering overall health care costs and increasing the size of provider networks.

Arbitrators can also consider additional information submitted by either party demonstrating why a particular dispute should deviate from the amount closest to the QPA. All arbitration decisions are binding and public; the *No Surprises Act* requires HHS to publicly report the outcomes from all arbitration cases quarterly on its website.

## Further Action

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As the implementation of the *No Surprises Act* continues, additional regulations and guidance must be developed to ensure the legislation serves its intended purpose. Work remains in state legislatures and in Congress to protect patients in all possible care scenarios. For example, ground ambulances, a common driver of surprise bills, still remain unregulated by the federal law. In addition, increasing consolidation amongst providers and hospitals must be addressed to promote greater choice and competition in health care, avoid market failures, and reduce health care costs across the board. Lastly, the *No Surprises Act* should correct underlying market failure – the lack of incentive for some providers to not participate in health plan networks – so that consumers have more access to high quality providers without any need to worry about a surprise medical bill.