"No Surprises Act"
Rulemaking Priorities
(additional items to be added)

As the Departments of Health and Human Services, Labor and Treasury undertake rulemaking to implement the “No Surprises Act,” the American Society of Anesthesiologists has identified the following priority elements that should be included in the rule:

Arbiter Consideration of Factors

The regulation should clearly define that the arbiter in the Independent Dispute Resolution (IDR) process must consider all factors equally. The No Surprises Act outlines certain criteria that the arbiter must weigh when determining whether the health plan’s offer or the physician’s offer is to be accepted. The criteria include the “qualified payment amount” (QPA)/median in-network amount, any additional information requested, the physician’s level of training and experience, the parties’ market shares, and other factors. The law does not specify how the factors are to be weighed. The rule should specify that all factors must be considered equally.

Accurate Definition of Qualified Payment Amount

The regulation defining the QPA/median in-network amount should specify appropriate criteria to ensure an accurate definition of the amount. Under the law, the QPA is defined as the median of the contracted rates recognized by the plan as the total maximum payment in the geographic area where the service was delivered. However, further definition is required. As a part of rulemaking, the agencies should include in the definition of QPA the actual amounts paid weighted by the number of actual payments issued to individually contracted physicians of the same specialty. The physicians’ level of training should also be considered.

Batching/Bundling of Claims

Anesthesiologists should be allowed to batch or bundle claims by either the individual physician or the group entity submitting the claim. The No Surprises Act allows a “provider” to bring multiple disputed items/services to the IDR process to be jointly considered in a single determination. The opportunity to resolve multiple claims disputes in one determination will reduce the time and cost associated with the IDR process. However, the law does not define “provider.” The regulation should clarify that the definition of “provider” includes either an individual physician or the group entity submitting the claim, such as a group (composed of multiple providers) identified by a common Tax Identification Number or TIN.

Application of the Federal IDR Process to States

The regulation should clarify that the federal IDR process should be applicable in those states that have limited surprise medical billing laws or state laws that have no or limited access to an IDR process. In states where physicians cannot resolve billing disputes through an IDR process (i.e., where there is no state IDR process; where the state imposes limitations on access to IDR; or where IDR is a voluntary process that parties can opt out of), access to the federal IDR process must be ensured.