



Key Provisions of Recently-Passed Legislation to Address Surprise Medical Bills

In December 2020, Congress advanced the Consolidated Appropriations Act, or H.R. 133, legislation to not only fund the federal government and provide COVID-19 economic relief, but also address surprise medical bills through a section titled, The No Surprises Act.

Key provisions of the Act are effective January 1, 2022 and are summarized below. However, significant rulemaking will be required to facilitate implementation of this law.

The No Surprises Act law protects patients from surprise medical bills and creates an Independent Dispute Resolution (IDR) Process to address billing issues. The IDR process is similar to models utilized in Texas and New York.

The law prohibits surprise billing (balance billing) by providers and facilities in emergency and non-emergency situations.

Patients are only responsible for in-network cost-sharing. There are also transparency requirements for plans and providers as it relates to providing the patient information, including up-to-date directories. The law also stipulates:

- Plans will make an initial payment to the out-of-network provider.
- If there is a payment dispute, providers and plans can attempt to negotiate for 30-days before arbitration begins.
- After 30 days, the physician can elect to enter into arbitration.
- There is no threshold to enter into arbitration and disputed claims can be batched together.
- The arbiter can consider all information submitted by the provider and insurer, including the median in-network rate, complexity of the case, and market power of the provider and payor, among other things. However, the mediator cannot consider public payor rates (e.g., Medicare and Medicaid) or billed charges.
- This arbitration process is baseball-style (each party submits an offer, and the mediator has to choose one of the two offers). The decision is final, and payment must be made within 90 days. The loser is responsible for the fees.
- Providers and insurers cannot initiate a new arbitration process for 90-days for the same item/s or service/s. However, payors are still required to provide regular payments to providers within this window. Providers can continue to collect and batch cases during the “cooling off” period and submit them for arbitration after the 90 days concludes.
- Two years after enactment, an interim report must be submitted to Congress to ensure rigorous oversight of the development of the arbitration process.

ASA will be releasing its initial comments for the rulemaking process in the coming days.