THE NO SURPRISES ACT

"Surprise billing" patients for unexpected out-of-network care is deeply unfair and financially devastating to families. It must be stopped. Patients deserve the peace of mind to know that, whether in an emergency or a planned in-network procedure, they will not be hit with crushing, surprise medical bills for out-of-network treatment beyond their control.

The No Surprises Act will end surprise bills for patients – so patients are only responsible for their usual in-network cost-sharing amounts and deductibles.

- **No surprise bills for emergency care:** Whether a patient is taken to an out-of-network ER or treated at an in-network ER but by a medical provider who is not covered by their insurance, they are now protected.
- **No surprise bills for scheduled care:** The bill forbids out-of-network health care providers from balance billing patients for scheduled care unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care. The bill also provides protections against surprise bills and a period of transition for patients with complex care needs if their network changes.
- **No surprise air ambulance bills:** Patients will only be required to pay the in-network cost-sharing amount for out-of-network air ambulances, protecting vulnerable patients from tens of thousands of dollars in crushing surprise bills when urgent medical transport is necessary.

With patients protected, the No Surprises Act creates a fair process for health care providers and health plans to sort out the out-of-network costs between themselves – without the patient stuck in the middle.

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Frequently Asked Questions

Why is the No Surprises Act needed?

- Every year, millions of Americans are affected by surprise medical bills, when they are billed for unexpected out-of-network care in an emergency or even scheduled procedures at an in-network facility.
- Roughly one in six hospital visits results in a surprise medical bill and a majority of Americans say they or someone they know have received a surprise medical bill.
- These surprise bills can range anywhere from hundreds of dollars to hundreds of thousands of dollars – a devastating burden on families who rightly expected their insurance to cover them.
- Patients shouldn't be caught in the middle when health care providers and health care plans don't agree on how much is owed.

Will patients be on the hook while their health care provider and their health plan argue about payment?

- No. Patients will only be responsible for their usual in-network cost-sharing amounts and deductibles and can go on with their lives.

- With the patient out of the middle, the No Surprises Act creates a fair process for providers and plans to settle payment between themselves.
- This bill provides for enhanced consumer protections including the ability for patients to appeal a surprise medical bill decision made by their insurer.

How will the providers and insurers sort out disputes over payment?

- The proposal allows insurers and providers to either negotiate payment between themselves or access a baseball-style independent dispute resolution (IDR) process when agreement cannot be reached.
- The IDR process will be administered by independent, unbiased entities with no affiliation to providers or issuers.

Does the proposal require the insurer to pay a specific amount to out-of-network providers?

- No, the proposal does not require the insurer to pay a specific amount to out-of-network providers, instead it allows insurers and providers to negotiate payment between themselves or access the IDR process when agreement cannot be reached.

What claims are eligible for the IDR process?

- Any claim, regardless of the amount disputed, may qualify for IDR.

What factors will be taken into consideration as part of the IDR process?

- The proposal recognizes that every medical claim is unique, therefore insurers and providers may submit any information relating to the dispute to the independent arbiter who will then consider all factors equally before determining the appropriate payment.
- For example, local median in-network rates, prior contracted rates, the complexity of the case, good faith efforts (or lack of good faith efforts) to enter into network agreements, or the market share of both parties may be considered.

Will payment be made to the providers of out-of-network services?

- Providers would be guaranteed direct payment for out-of-network services, which is an improvement from the status quo for all providers.

Does the proposal preempt state solutions for resolving out-of-network payment?

- No, the proposal does not preempt state solutions for resolving out-of-network payment but establishes a standard for patient protections that state laws must meet.

What about the medical bills of Americans who can't afford insurance in the first place?

- From day one of our majority, House Democrats have worked to make quality health coverage affordable to all Americans, including through other bills like the Affordable Care Enhancement Act which would make coverage more affordable for at least 13 million more, likely benefiting well over 17 million people in total.
- Democrats will continue our work to lower health costs and prescription drug prices.

Will this proposal harm health care providers working in good faith?

- The arbitration process will specifically consider demonstrations of good faith efforts (or lack of good faith efforts) to enter into network agreements.
- Reimbursement rates would be reduced primarily amongst the small segment of providers who have been charging exorbitant rates for their services because of their use of the balance billing strategy.

How does this proposal increase transparency in the health care system?

- The proposal requires that insurers and providers maintain up to date provider directory information.
- Requires insurance cards to clearly display in-network and out-of-network deductibles and out-of-pocket limitations.
- Insurers and providers must also coordinate to provide patients with good faith cost estimates in advance of services.

When does the legislative proposal take effect?

- In 2022, therefore providing a one-year period for the necessary regulations to be promulgated to give health care providers and insurers sufficient time to adjust and prepare for implementation.

Did this legislation go through regular order?

- Yes, the final agreement is not new legislation – it builds upon the work that the committees did during their mark-ups over the last 18 months. Surprise billing legislation was marked up in each of the committees and was overwhelmingly advanced out of the committees with bipartisan support.

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