# Congress Ends Surprise Billing: Implications for Payers, Providers, and Patients

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*The No Surprises Act represents a rare bipartisan moment for Congress and a long-needed safeguard for patients that will reorient relationships among payers and providers.*

**ABSTRACT**

Compromise over ending surprise billing had consistently hit a deadlock as providers, payers, and patient groups found themselves at odds over mechanisms to resolve payment. The COVID-19 pandemic, however, accelerated legislative action on health care proposals, leading to the last-minute passage of the No Surprises Act at the end of 2020. The law marks a rare bipartisan success that promises to secure patient protections while also adding price transparency tools. Importantly, it creates an independent dispute resolution process that balances the demands of payers and providers in negotiating surprise billing. While the cost implications of this process will not be known until after implementation in 2022, it creates a template for states to emulate. Furthermore, it will reorient the relationships among payers and provider groups that have historically relied on out-of-network billing. This new competitive reality is an important step for consumer financial protection in health care.

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**Takeaway Points**

Starting in January 2022, patients will enjoy protections against surprise billing, as well as new price transparency tools.

- Enrollees in self-insured plans now have a mechanism for dispute resolution over surprise bills.
- The dispute resolution process is “final-offer” arbitration and should moderate offers by both payers and providers.
- Out-of-network providers are restrained in their ability to balance bill.
- Payers and providers are responsible for providing timely cost data to patients for potential services.

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As 2020 came to a close, the 116th Congress raced to address the economic fallout of the COVID-19 pandemic, passing a $2.3 trillion omnibus spending bill. This nearly 5600-page bill provided $900 billion in stimulus spending, with coronavirus economic relief and government funding for the fiscal year, along with numerous provisions on long-controversial issues. This included the No Surprises Act, which will protect consumers from surprise medical bills beginning January 1, 2022. The act represents a rare bipartisan breakthrough with important implications for patients, physician practices, and health plans.

**Need for Federal Action**

Surprise billing represents a health care market failure wherein patients receive out-of-network services from physicians whom they did not knowingly choose. This often occurs in emergency situations and when patients are at an in-network facility where some physicians or laboratory services are not in the same networks as the facility. In such cases, the out-of-network physician bills their full charges to the patient’s insurer, then bills the patient directly for any remaining balance between the charge and allowed amount. Surprise billing is exceptionally difficult to avoid even for the most assiduous of consumers, as 1 in 5 elective surgeries at an in-network facility with an in-network lead surgeon involve an out-of-network charge.[1] National attention has focused in on the issue as headlines touted eye-popping sums charged to patients, like a $117,000 surprise bill from assistant surgeons.[2]

Federal legislation to address surprise billing had been under debate for 2 years, with a half dozen bills introduced in the congressional term. Compromise was hampered by competing interests among physicians, payers, consumer advocates, and hospitals, as well as high-

stakes lobbying campaigns by private equity–backed groups in 2019.[3] By 2020, the White House had to step into the fray and threatened to intervene if Congress made no action by 2021.

Congress faced pressure from constituents: 78% of those polled in 2020 supported federal legislation against surprise medical bills.[4] One in 6 commercially insured adults had an unexpected out-of-network physician bill, and two-thirds worried about affording these unexpected expenses. Broader trends may exacerbate surprise billing, with narrow-network plans becoming more prevalent and the COVID-19 pandemic creating new medical needs.[5]

**Compromise**

The No Surprises Act bans surprise billing in a range of scenarios, including for emergency services delivered by out-of-network providers or facilities, as well as for nonemergency services provided by out-of-network providers at in-network facilities and for which patients do not consent. Patients are protected from additional charges beyond their insurer's in-network cost-sharing requirement, and providers are banned from billing for any higher amounts.

Physicians and consumer protection advocates will also be glad to see the use of consent waivers in the No Surprises Act. Elective out-of-network physicians can seek advance written consent from patients that then allows them to send balance bills. This enables patients to knowingly seek treatment from an out-of-network physician and bear the additional cost, having been provided a good-faith estimate of the costs of the services. With this provision, the No Surprises Act does not limit informed contracting between physicians and patients.

In a move for greater health care cost transparency, both payers and providers will be responsible for ensuring that patients have adequate price information. Providers must submit to health plans a good-faith estimated amount of billing and service codes for all expected services prior to the event, and health plans must in turn provide enrollees with an "Advanced Explanation of Benefits" prior to scheduled care or upon request. Payers must periodically ensure that their provider directories are current and have 1 business day to respond to enrollees' inquiries about a provider's network status. Researchers will also have access to better cost data, as the act authorizes grants to states to establish or improve their All-Payer Claims Databases.

The most contentious aspect of regulating surprise billing has been settling payment amounts between insurers and out-of-network physicians. Certain emergency and facility-based physician groups have benefited financially from staying out of network and recouping high charges via surprise bills, and they have resisted legislative attempts to stem out-of-network billing. As a result, they have advocated to continue tying out-of-network payments to billed charges. They have also favored arbitration approaches that allow for payment flexibility based on the facts of each case, like a physician's expertise or patient's condition.

Insurers and self-insured employers, meanwhile, found themselves absorbing the high costs of out-of-network bills. They lobbied to divorce out-of-network payments from billed charges and instead use in-network rates or multiples of Medicare rates as payment benchmarks. Rather than an unpredictable arbitration process, they instead supported a fixed payment standard.

The No Surprises Act strikes a compromise among stakeholders by employing an independent dispute resolution process, or arbitration, and allowing arbitrators to consider in-network benchmarks as a part of decision-making. It narrows the arbitrator's view of prices by prohibiting them from considering either billed charges or public payer rates, which represent the high and low ends of rates, respectively. In a move favoring physician groups, the arbitrator can take into account a physician's training and experience, as well as the acuity of their patients and complexity of their case mix. Notably, it also allows the arbitrator to consider the market share of both parties. Insurers and physicians have a 30-day negotiation period, which converts to arbitration if negotiations fail. This arbitration process is "final offer," wherein each party submits an offer and basis for that offer, and the mediator selects 1 offer within 30 days. The chosen offer is binding and the parties cannot reinitiate the process for 90 days. The "final-offer" style of arbitration should restrain offers, as each party tends to avoid offers at price extremes so as not to appear unreasonable, and because the losing party must pay the arbitration costs.

**Implications**

Under this law, the small share of physicians who disproportionally engaged in surprise billing will have to change course and will certainly see revenue losses. There may also be weakened payment negotiation leverage for in-network specialist physicians who were in a position to surprise bill if they had been out of network. This is because their best alternative to a negotiated agreement with insurers will be lowered from their full billed charges to the new equilibrium payment under arbitration. The Congressional Budget Office projects that the No Surprises Act could reduce commercial insurance premiums by 0.5% to 1%, with savings derived from reduced payment to those specialists who benefited directly and indirectly from the ability to surprise bill.[6]

While awaiting federal action, states had enacted their own policies in the previous decade, with 32 states adopting some form of protections, although only 16 had comprehensive protections.[7] State actions, however, cover only the fully insured half of the commercially insured population because self-insured plans are federally regulated by the federal

Employee Retirement Income Security Act of 1972, also called ERISA. These state rules will supersede the No Surprises Act, so in many states there will continue to be state-based regulation of fully insured plans' out-of-network payments alongside the federal regulation of self-insured plans. Physicians in these states will have to navigate the parallel federal-state systems, which may prove onerous for small physician practices. To ease this regulatory burden, states may consider bringing their laws in line with the federal approach. Finally, the No Surprises Act extended protections to those who use air ambulance services—a key move since states were barred from regulating these services under the Airline Deregulation Act—but it does not protect those who use ground ambulance services. States should take the next step of regulating bills from these services.

The No Surprises Act was a surprising example of bipartisanship and legislative momentum that builds on the piecemeal efforts of states. The arbitration approach incorporating a market-based benchmark strikes a compromise among the competing interests of physicians and payers. It should reduce gamesmanship among parties and reduce consumer costs, albeit while adding regulatory complexity for some physician practices. Physician groups that previously depended on out-of-network billing will have to adapt to the new competitive reality in 2022 when the No Surprises Act takes effect, but for patients it will be an empowering reform that promises transparency and fairness.

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