

# *“No Surprises Act”*

## AAOS Summary and Analysis

### Background

AAOS has been working with Congress since 2018 to end surprise medical bills for patients. We have remained steadfast that any federal solution must remove patients from the middle of billing disputes and create a process for negotiation between physicians and insurers including Independent Dispute Resolution (IDR), batching of claims, and no dollar amount threshold. We fully supported the “Protecting People from Surprise Medical Bills Act,” the first piece of federal legislation to include an IDR process and a sharp contrast to other federal bills that would have amounted to government rate setting. On December 11, 2020, Congressional leadership announced a compromise had been reached on surprise billing legislation. While the “No Surprises Act” began as a rate-setting solution that would have heavily favored insurers, AAOS and a coalition of physician and hospital groups moved Congressional negotiators towards an IDR process. AAOS will continue to advocate to improve on the IDR process and all the bill’s provisions at every opportunity, including in crucial federal rulemaking following expected passage of the legislation.

### No Surprises Act

- Prohibits providers from sending out-of-network patients balance bills for more than in-network cost-sharing in the following situations:
  - Out-of-network emergency care,
  - Ancillary services provided by out-of-network providers at in-network facilities, and
  - Out-of-network care provided at in-network facilities without the patient’s consent.
- Balance billing is allowed in non-emergency situations when the patient is given notice of out-of-network status and an estimate of charges 72 hours prior to procedure. For appointments made within 72 hours, the patient must receive notice the day the appointment is made.
- The legislation does not preempt state law, meaning in states that have passed balance billing bans and dispute mechanisms the state law will continue to apply for state regulated health plans. Federally regulated ERISA plans and state regulated plans in states without a surprise billing law will be subject to the patient protections and dispute resolution process created by the No Surprises Act.
- The bill creates a 92-day process for resolving disputed bills, including:
  - 30 days for open negotiation process between the provider and insurer,
  - If no agreement, 2 days for either party to initiate IDR process,
  - 30 days for IDR entity to make payment determination, and
  - 30 days for insurer to make payment.
- The IDR process is “baseball-style,” meaning both parties will provide their best offer to an independent arbiter. The arbiter then makes the final decision.
- There is no dollar amount threshold for access to IDR included in the legislation.
- In making its decision, the IDR entity will consider at equal weight:
  - The median in-network rate for the products of that insurer in the geographical area,
  - Information requested by the reviewer,

- Provider's training and experience,
  - Market share held by the physician or facility,
  - Patient acuity and complexity of furnishing the item or service,
  - Demonstrations of good faith or lack thereof to enter into network agreement,
  - Prior contracted rates, and
  - Any other relevant information brought by either party (not including physician charges, which were not included because the non-partisan Congressional Budget Office determined it would have an inflationary effect).
- Batching of claims into a single IDR decision is allowed for items and services treating same or similar condition furnished during a 30-day period.
  - Following the initiation of the IDR process, there is a 90-day waiting period for a party to take the same party to IDR for the same service. However, claims arising from services performed during those 90 days can still be taken to IDR following the waiting period.
  - The losing party pays the IDR fees, which will be determined by the U.S. Department of Health and Human Services (HHS) in order to cover the cost to the department of administering the IDR process. If a settlement is reached each party pays half of the IDR fees.
  - HHS can apply a monetary penalty for violations of the balance billing ban up to \$10,000. The department can establish a hardship exemption.
  - Transparency requirements include mandating that health plans provide insurance cards clearly displaying in-network and out-of-network deductibles and out-of-pocket limitations.
  - Timely billing requirements include a 30-day requirement for providers to bill health plans, 30 days for plans to adjudicate the bill, and 30 days for the provider to send the adjudicated bill to the patient. The timeline may be extended in the case of billing disputes.
  - The legislation's effective date is January 1, 2022.