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IN FOCUS

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Surprise Billing: Independent Dispute Resolution Process

This In Focus summarizes statute and interim final rule (IFR) regulations to describe the independent dispute resolution (IDR) process available to insurers and out-of-network providers in certain surprise medical billing situations. It accounts for IFR aspects invalidated in the *Texas Medical Association v. U.S. Department of Health and Human Services* decision but predates a federal response to that decision.

For more information on surprise billing in general and corresponding consumer protections, see CRS Report R46856, *Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services*. For more information on the litigation related to the IDR process, see CRS Insight IN11906, *No Surprises Act's Independent Dispute Resolution Process and Related Litigation*.

Surprise Billing

In general, surprise billing occurs when consumers are unknowingly, and potentially unavoidably, treated by providers outside of their health insurance plan's network. As a result, these consumers unexpectedly receive larger bills than they would have received had the provider been in their plan's network. To address surprise billing, Congress passed the No Surprises Act, which was part of the Consolidated Appropriations Act, 2021 (P.L. 116-260).

Among other requirements, the No Surprises Act specified a methodology to determine the amount insurers must pay to providers for services provided in the following surprise billing situations: out-of-network emergency services, nonemergency services provided by an out-of-network provider at an in-network facility, and out-of-network air ambulance services. (For post-stabilization services [in limited circumstances] and out-of-network nonemergency, non-ancillary services provided at an in-network facility, the federal methodology would not apply if notice and consent requirements were satisfied.) The amount an insurer pays, when combined with amounts consumers pay in cost sharing, represents the total amount a provider receives as payment for services.

Methodology to Determine Insurer Payment to Providers

Under the federal methodology, insurers must make an initial payment (or notice of denial of payment) to the provider, after which the provider or the insurer may initiate open negotiations to determine an agreed-upon payment amount for the services. If negotiations are unsuccessful, the parties may use an IDR process, which is a "baseball-style" arbitration process.

This methodology does not apply in all situations. If a state has its own surprise billing law that pertains to a given plan type, provider type, and service, the state law methodology would apply. In addition, if a state has an all-payer model agreement, the amount designated under the agreement would apply.

Initial Payment

Insurers are required to make an initial payment (or notice of denial of payment) to a provider within 30 calendar days of receiving a bill for services. Federal law and regulations do not specify how to determine the amount of the initial payment, though it should be an amount that the insurer intends to be payment in full (i.e., not a first installment).

Open Negotiation

After the insurer makes an initial payment (or notice of denial of payment), the provider or the insurer may initiate open negotiations during the subsequent 30-business-day period by providing a notice to the other party. The parties then have 30 business days from the date the notice was sent (i.e., the open negotiation period) to reach an agreement on the payment amount. If the negotiations are successful, the insurer is required to pay to the provider the agreed-upon amount (or, after accounting for the initial payment, any remaining balance) within 30 calendar days.

Independent Dispute Resolution Process

If a provider and insurer cannot reach an agreement during the open negotiation period, then either party may initiate the IDR process. The IDR process is a baseball-style arbitration process under which the provider and the insurer each submit to a neutral, certified third-party arbitrator (i.e., IDR entity) their best and final offers that represent the amount that each party considers adequate payment. The IDR entity must review both offers and make a determination based on certain factors as to which of the submitted offers is the final payment amount.

The provider and the insurer have four business days following the end of the open negotiation period to initiate the IDR process by submitting a notice to the other party and the federal government. In some instances, a provider and insurer seeking resolution regarding multiple identical (or similar) services can combine (or "batch") the services to be considered as part of a single IDR determination.

If initiated, the parties have three business days to jointly select an IDR entity. If the parties do not make a selection by the deadline, they must notify the Departments of the Treasury, Labor, and Health and Human Services (tri-agencies) on the fourth business day and the tri-agencies will randomly assign an IDR entity within six business days of the IDR process initiation. Once selected, the IDR entity

must attest whether it satisfies conflict of interest requirements within three business days. The IDR entity also must determine whether the IDR process applies to the situation and, if it is determined that the process does not apply, the IDR entity must notify the tri-agencies and the parties within three business days of the determination.

At the time the IDR entity is selected, both parties must pay an administrative fee to the tri-agencies for participating in the IDR process. This fee amount is set annually so that the total amount of fees collected equals the total estimated cost for the tri-agencies to carry out the IDR process. For 2022, the administrative fee is $50. This fee is initially collected by the IDR entity, which then remits the fee to the government.

No later than 10 business days after the IDR entity has been selected, the provider and the health insurer each must submit to the IDR entity an offer for the payment amount; any information requested by the IDR entity; and, if so choosing, other information related to the offer. At this time, both parties must pay a fee to the IDR entity for its payment determination services. (This fee is in addition to the administrative fee.) Each IDR entity can determine its own fee amount, but generally these fees will fall in between a range determined annually by the federal government. For 2022, the fee range for a single determination is $200-$500; for batched determinations, it is $268-$670. IDR entity fees are held in a trust or escrow account until a final determination is made.

After the IDR process is initiated but before there is a determination, insurers and providers may continue to negotiate a payment amount. If the parties reach an agreement through negotiation during this period, the agreed-upon rate is treated as the final payment rate. The parties would split the IDR entity fee unless the parties agree otherwise. The administrative fee is nonrefundable.

The IDR entity has 30 business days from the entity's selection to determine which of the submitted offers represents the payment amount. To make this decision, the IDR entity must consider the insurer's 2019 median in-network amount for the same or similar service provided by a provider in the same or similar specialty in the same geographic region (indexed for inflation), which is referred to as the *qualifying payment amount*, or QPA. The IDR entity also must consider a set of additional circumstances if submitted by the parties (specified below), any information requested by the IDR entity, and any other information about the submitted offer supplied by the provider or the insurer. To be considered, this information must be credible and must not include information that the IDR entity is prohibited from considering.

For all situations, excluding air ambulance, the IDR entity is required to consider the following (if submitted): (1) the level of training, experience, and quality and outcomes measurements of the provider that furnished the service; (2) the market share of the provider or insurer in the geographic region where the service was provided; (3) the acuity of the individual receiving the service or the complexity of furnishing the service to the individual; (4) the teaching status, case mix, and scope of services of the facility that furnished the service; and (5) demonstrations of good faith efforts (or lack thereof) made by the provider or the insurer to enter into network agreements and, if applicable, contracted rates between the provider and the insurer during the previous four plan years.

For air ambulance situations, the IDR entity is required to consider the following (if submitted): (1) quality and outcomes measurements of the provider that furnished the service; (2) acuity of the individual receiving the service or the complexity of furnishing the service to the individual; (3) training, experience, and quality of the provider that furnished the service; (4) ambulance vehicle type, including the clinical capability level of the vehicle; (5) population density of the pick-up location (e.g., urban, suburban, rural, or frontier); and (6) demonstrations of good faith efforts (or lack thereof) made by the provider or the insurer to enter into network agreements and, if applicable, contracted rates between the provider and the insurer during the previous four plan years.

In all situations, the IDR entity is prohibited from considering usual and customary charges, the amount that would have been billed by the provider for the service had the surprise billing protections not applied, and the amounts that public payors (including Medicare, Medicaid, the Children's Health Insurance Program [CHIP], or TRICARE) would pay or reimburse the provider for the service.

After considering the qualifying payment amount, additional circumstances, and any additional information, the IDR entity must select the offer that best represents the value for the services under consideration. The IDR entity's decision is binding on both parties, unless there is fraud or an intentional misrepresentation of facts. A binding payment determination generally is not subject to judicial review except in limited situations.

After the IDR entity makes a decision, if the payment decision is more than the initial payment, the insurer must pay the remaining balance to the provider within 30 calendar days of the decision. If the payment decision is less than the initial payment, the provider must reimburse the insurer within 30 calendar days of the decision. The party whose offer is not chosen is responsible for paying the IDR entity fee, and the IDR entity must refund the IDR entity fee paid by the party with the chosen offer within 30 business days.

During the 90 calendar days after an IDR decision has been made, the party that initiated the IDR process may not subsequently attempt to initiate the IDR process to seek a payment determination involving the same opposing party and the same (or similar) services that were subject to the initial determination. In instances where the same parties are again in a surprise billing situation regarding the same (or similar) service and the open negotiation period for such services ends during this 90-day "cooling-off" period, either party may initiate the IDR process within the 30 business days following the cooling-off period.

Ryan J. Rosso, Analyst in Health Care Financing

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