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IN FOCUS

March 1, 2023

The Federal Patient-Provider Dispute Resolution Process

Introduction

The No Surprises Act, part of the Consolidated Appropriations Act, 2021 (P.L. 116-260), established various consumer protections, including the prohibition of balance billing consumers in certain situations where an individual can be unknowingly, and potentially unavoidably, seen by an out-of-network provider (e.g., out-of-network emergency services). Separately, it also required all providers that schedule services to furnish *good faith estimates* of expected medical costs whenever an individual schedules to receive medical care (e.g., a scheduled doctor's appointment, a scheduled surgery) at least three days in the future. Building off of the latter requirement, the law also directed the Secretary of the Department of Health and Human Services (HHS) to establish a *patient-provider dispute resolution (PPDR) process*. Under this process as implemented by HHS, if an uninsured or self-pay individual receives a medical bill that is at least $400 more than the good faith estimate, an independent third party decides whether the individual is to pay the billed amount, the estimated amount, or an amount in between.

This In Focus provides an overview of the federal PPDR process. The federal PPDR process does not apply in states that have a similar PPDR process that meets specified requirements. As of the date of publication, no states had such a process, so the PPDR process applies in all states.

Eligibility

To be eligible to use the PPDR process, an individual who received medical care must meet the following criteria:

- Be uninsured or self-pay
- Have a bill estimate (i.e., a good faith estimate) from the provider
- Have a bill dated within the last 120 calendar days
- Have a bill from a provider that is at least $400 more than the provider's good faith estimate

Uninsured or Self-Pay

Uninsured refers to individuals who do not have any of the following forms of coverage: employer-sponsored coverage, non-group insurance, coverage under a federal health care program (e.g., Medicare, Medicaid), or coverage through the Federal Employees Health Benefits (FEHB) Program. *Self-pay* refers to individuals who have employer-sponsored coverage, non-group insurance, or FEHB coverage but who are not seeking to submit a claim to their insurance for the medical care.

Good Faith Estimate

When an uninsured or self-pay individual schedules to receive medical care from any provider or a facility (subsequently referred to simply as *a provider* to facilitate easy reading) at least three business days in the future, the provider must give the individual (or the individual's authorized representative) an itemized estimate of the amounts they expect to charge for the scheduled care (and any related items and services reasonably expected to be furnished). In some instances, the good faith estimate may include expected charges from multiple providers.

The estimate is to be based on information known at the time the estimate was scheduled; an individual ultimately can be billed more if complications or special circumstances occur.

Good faith estimates are to be provided either on paper or electronically within designated time frames. When care is scheduled at least three business days in advance, the estimate must be provided to the individual no later than one business day after scheduling. When care is scheduled at least 10 business days in advance, the estimate must be provided to the individual no later than 3 business days after scheduling. (Individuals also may request a good faith estimate, which must be provided to the individual no later than three business days after the request.) If there are changes in the scope of the estimate after the good faith estimate is initially provided, the provider must give the individual an updated good faith estimate at least one business day before the medical care is to be furnished.

Bill Substantially in Excess of Good Faith Estimate

Eligibility for the PPDR process is separately determined for each provider on the good faith estimate. To be eligible, the aggregate billed amount for all items and services from a particular provider must be at least $400 more than the aggregated, estimated amounts from that provider.

Good faith estimates can include amounts from multiple providers. As such, it is possible that an individual receives a good faith estimate with cost estimates for services from multiple providers, but upon receiving the bill(s), the individual is eligible to initiate the PPDR process with respect to only one provider.

Initiation

Qualified individuals (or their authorized representative) may initiate the PPDR process online or by mail or fax with HHS, which administers the process.

To do so, the individual must submit specified pieces of information with their initiation notice, including the individual's contact information, the provider's contact information, a copy of the bill, and a copy of the good faith estimate. Upon receiving this information, HHS is to select an independent, certified third-party (i.e., a Selected

Dispute Resolution (SDR) entity) to oversee the dispute resolution.

At this time, the SDR entity is to determine whether it has a conflict of interest with the individual or provider. If a conflict of interest exists, HHS is to select a new SDR entity. If the SDR entity finds no conflicts of interests with the individual or provider, the SDR entity must make an initial determination of the dispute's eligibility and the completeness of the initiation notice. If the SDR entity determines that an initiation notice is incomplete and additional information is required, the submitting individual generally would have 21 calendar days to submit the missing information.

Once an SDR entity is selected, the individual would be responsible for paying an administrative fee to the SDR entity, which is $25 for 2023. (This fee is to be remitted to HHS.)

Patient-Provider Dispute Resolution Process

The PPDR process begins if and when the SDR entity determines a dispute to be eligible, determines the initiation notice contains the required information, and then subsequently notifies the individual and the provider that the dispute is eligible for the PPDR process. As part of the notification, the SDR entity is to request that the provider furnish a copy of the bill; a copy of the good faith estimate; and, if available, documentation that demonstrates that the difference between the two reflects the cost of a medically necessary item or service and is based on unforeseen circumstances that could not have reasonably been anticipated by the provider when the good faith estimate was provided. The provider must submit this information to the SDR entity within 10 business days.

The individual and provider also have an opportunity to indicate whether or not a conflict of interest exists with the SDR entity.

At any point prior to a determination, the provider and individual can settle the payment dispute through either an offer of financial assistance or an offer of a lower amount, or an agreement by the individual to pay the billed charges in full. If this occurs, the provider is to notify the SDR entity of the agreement within three business days and is to reduce the settlement amount by at least half of the $25 administrative fee ($12.50).

Determination

Not later than 30 business days after receiving the requested information from the provider, the SDR entity must make a determination on the amount the individual must pay for the disputed medical care. More specifically, the SDR entity must make a separate determination for each unique item and/or service as to whether the provider demonstrated that the difference between the billed charge and good faith estimate reflects the cost of a medically necessary item or service and is based on unforeseen circumstances. In making this determination, the SDR entity must review the documentation submitted by the individual and provider.

The process for determining a final payment amount varies for items and services that appear on the good faith estimate and items and services that do not appear on the good faith estimate.

For items and services that appear on the good faith estimate, if the billed charge for a particular item or service is equal to, or less than, the corresponding charge on the good faith estimate, the SDR entity must determine that the cost of care for that item or service is the billed charge amount.

If the billed charge for a particular item or service is more than the corresponding amount on the good faith estimate, then the SDR entity must determine whether the difference reflects the cost of a medically necessary item or service and the occurrence of unforeseen circumstances. If the SDR entity determines that it does not, the SDR entity must determine that the cost of care for that item or service is the good faith estimate amount. If the SDR entity determines that it does, the SDR entity must determine that the cost of care for that item or service is the lesser of (1) the billed charge amount or (2) the median payment amount paid by a plan for the same or similar item or service by a same or similar provider in the geographic area where the services were provided (as determined by an independent database). However, if the median payment amount is less than the good faith estimate amount, then the good faith estimate amount is to be used instead.

For items and services that do not appear on the good faith estimate, the SDR entity must also first determine whether the relevant billed charge amount reflects the cost of a medically necessary item or service and the occurrence of unforeseen circumstances. If the SDR entity determines that it does not, the SDR entity must determine that the cost of care for that item or service is $0. If the SDR entity determines that it does, the SDR entity must determine that the cost of care for that item or service is the lesser of (1) the billed charge amount or (2) the median payment amount paid by a plan for the same or similar item or service by a same or similar provider in the geographic area where the services were provided (as determined by an independent database).

If the SDR entity determines that the total amount to be paid by the uninsured or self-pay individual is less than the total billed charges, the individual is considered the prevailing party. In those instances, the final determination amount the individual would pay would be reduced by $25 (i.e., the amount of the administrative fee). The SDR entity's decision is binding on both parties, unless there is fraud or an intentional misrepresentation of facts or if the parties agree to a different payment amount. The provider may, for instance, choose to provide financial assistance or otherwise agree to an amount lower than the SDR entity's determination, or the individual may agree to pay the billed charges in full.

In October 2021 interim final rules, HHS estimated that over 26,000 claims would result in patient-provider dispute resolution cases each year.

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