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Regulating Balance Billing in the Private Sector: Should the Federal Government Leave Well Enough Alone?

Georgie Bierwirth

REGULATING BALANCE BILLING IN THE PRIVATE SECTOR: SHOULD THE FEDERAL GOVERNMENT LEAVE WELL ENOUGH ALONE?

I. Introduction

Imagine thinking you are dying. You are paralyzed on your bedroom floor because of a heart attack. Luckily, your neighbor finds you and takes you to the nearest hospital. You survive. You have insurance, so you should not be too worried about the medical bill, right? But after a successful surgery, you receive a medical bill for a whopping $108,951.[1] This scenario is not just a hypothetical. Sadly, it is not unique either. A man named Drew Calver lived this experience.[2] He survived his traumatic heart attack, but at what cost? The neighbor that saved Calver's life could have potentially put Calver in a life of debt. The hospital to which Calver's neighbor brought him was out-of-network for Calver's insurance.[3] Therefore, his insurance only covered $55,840 out of the exorbitant bill totaling $164,941.[4] Luckily for Calver, after National Public Radio (NPR) caught wind of his story and reported on it, the hospital lowered Calver's bill to a more reasonable $331.[5] However, most individuals facing a similar experience are not as fortunate. They do not have a journalist pressuring the hospital to lower their bill. This is the horror of balance billing.

This Comment analyzes whether the current federal solution to combat balance billing, the No Surprises Act (H.R. 3630), is sufficient or whether the federal government must continue to reevaluate its recent proposals in order to provide for a more comprehensive plan to limit the effects of balance billing on the American people. Part II of this Comment explores the scope of balance billing and the various situations in which this practice traditionally occurs.[6] Next, this Comment explains the limited ways the federal government has addressed balance billing in terms of Medicaid and Medicare as well as several state solutions developed to combat the issue of balance billing in the

1. Libby Watson, *The Grim Lottery of Surprise Medical Bill Stories*, The New Republic (Oct. 10, 2019), https://newrepublic.com/article/155334/grim-lottery-surprise-medical-bill-stories.
2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. *See infra* Part II.A.

private sector.[7] Part II also delves into the four factors that result in comprehensive balance billing regulation.[8] Part III provides an analysis of the three major balance billing proposals in Congress[9] in terms of both the four comprehensive factors and the factors solely applicable to federal balance billing regulation.[10] Lastly, Part IV discusses the impact of these regulations and the constitutional issues that may arise from enacting balance billing regulation at the federal level.[11]

Ultimately, although some states have enacted more extensive balance billing laws and issues will inevitably arise from the federal government's attempt at regulating balance billing in the private sphere, the federal government made the correct decision by adopting the No Surprises Act because it is a more comprehensive solution to balance billing.

II. Background

The "practice of balance billing refers to a physician's ability to bill a patient for an outstanding balance after the insurance company submits its portion of the bill."[12] This type of billing occurs with both private and public insurance, yet the federal government has traditionally only regulated balance billing in the public sphere, when patients utilize Medicaid or Medicare.[13] As a result, many states have taken it upon themselves to enact laws to address balance billing in the private sector.[14] However, not all states' balance billing regulations meet the four factors that constitute comprehensive regulations.[15] There are also several areas that state laws cannot regulate.[16] The federal government's intervention in regulating balance billing in the private insurance market is thus necessary. Various federal balance billing proposals and recently enacted legislation attempt to com-

7. *See infra* Part II.B–C.

8. *See infra* Part II.C.

9. At the time of this writing, the three major balance billing regulations in Congress were the Consumer Protections Against Surprise Medical Bills Act of 2020, H.R. 5826, 116th Cong. (2020); the Ban Surprise Billing Act of 2020, H.R. 5800, 116th Cong. (2020); and the No Surprises Act of the 2021 Consolidated Appropriations Act, Pub. L. No. 116-260, 134 Stat. 1182, 2756 (2022).

10. *See infra* Part III.

11. *See infra* Part IV.

12. Brooke Murphy, *20 Things to Know About Balance Billing*, Becker's Healthcare (Feb. 17, 2016), https://www.beckershospitalreview.com/finance/20-things-to-know-about-balance-billing.html.

13. *See infra* Part II.B.

14. *See infra* Part II.C.

15. *Id.*

16. *See infra* Part II.D.

bat the issues surrounding balance billing, each of which uses a slightly different approach.[17] However, since Congress ultimately adopted only one bill, each proposal must be evaluated to determine whether the recently enacted legislation is the best option for regulating balance billing.

A. Scope of Balance Billing

Balance billing occurs when a physician bills a patient for the remaining balance on a medical bill after the patient's insurance company has already paid the physician its portion of the bill.[18] This type of billing is also referred to as "surprise medical billing" because patients do not expect to receive a bill directly from the treating hospital because they believe their insurance covered the entire cost of care.[19] However, the patients may not have realized that the care they received was not in-network coverage, or the patients may have thought their insurer was going to contribute more money for a service than the insurer actually did.[20]

Balance billing typically occurs in two situations.[21] First, a provider may bill a patient when a patient receives emergency medical care from an out-of-network healthcare provider (as was the case for Drew Calver).[22] A federal law, the Emergency Medical Treatment and Labor Act (EMTALA), prevents hospitals operating under Medicare from turning away patients who need emergency medical attention simply because the patients may not have insurance or because the treating hospital may not be in the patient's insurance network.[23] Other times, the hospital may be in-network, but a patient's insurer does not cover the costs associated with emergency room doctors and staff who treat the patient.[24] Obviously, when such a facility or provider uses its resources to treat a patient with an emergency medical condition, the treating entity wants to get paid. However, since most insurance companies often refuse to pay the costs of out-of-network

17. *See infra* Part II.E.

18. Murphy, *supra* note 12.

19. Jaime Rosenberg, *5 Things About Surprise Medical Billing*, Am. J. Managed Care (Sept. 6, 2016), https://www.ajmc.com/view/5-things-about-surprise-medical-billing.

20. Murphy, *supra* note 12.

21. Paul D. Clement, Federal "Balance Billing" Legislation: Constitutional Implications, Kirkland & Ellis LLP 6 (2019), https://www.scribd.com/document/414001118/Paul-Clement-Balance-Billing-Constitutional-Implications-June-2019.

22. *Id.*; Watson, *supra* note 1.

23. 42 U.S.C. § 1395dd (2011).

24. Murphy, *supra* note 12.

emergency care, hospitals are forced to bill the patients for the balance that their insurer refuses to provide.[25]

Second, balance billing frequently occurs when a patient receives care at an in-network facility, but the care comes from an out-of-network provider.[26] For instance, a patient may choose a hospital for surgery because it is within his insurer's network.[27] But if, for example, the anesthesiologist or radiologist that treats the patient chooses not to participate in that network,[28] the patient's insurance provider will likely not cover the services performed by the out-of-network physicians.[29] The patient, however, is completely unaware of the provider's relationship to his insurance company and that, as a result, his insurance will not cover portions of the bill.[30] This situation commonly occurs when a patient requires air ambulance services.[31] When circumstances necessitate such ambulatory services, patients usually do not have the time or physical capability to select an air ambulance, much less choose an air ambulance that their insurance plan may cover.[32] In this situation, insurance companies will not cover the cost of air ambulance services if they are out-of-network, and such services tend to be quite expensive, having an out-of-pocket cost of roughly $24,500 per trip.[33] As a result, in order to recoup some of the costs of care, providers will then attempt to leave the patient with the bill.[34] Receiving an expensive bill for services from an out-of-network provider working at an in-network hospital is especially unnerving for patients who carefully planned to receive treatment at an in-network facility yet inadvertently end up paying a higher cost.[35] However, some laws exist to alleviate the significant financial burden that balance billing places on patients.[36]

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25. CLEMENT, *supra* note 21, at 6.

26. *Id.*

27. Murphy, *supra* note 12.

28. *Id.*

29. CLEMENT, *supra* note 21, at 6.

30. Murphy, *supra* note 12.

31. *Id.*

32. Joan Stephenson, *Solutions for Air Ambulance Surprise Billing in Holding Pattern*, JAMA (Mar. 4, 2020), https://jamanetwork.com/channels/health-forum/fullarticle/2762706.

33. Ethan Kispert, *FAIR Health Report Shows 76.4% Increase for In-Network Air Ambulance Costs*, ST. REFORM (Oct. 4, 2021), https://stateofreform.com/featured/2021/10/fair-health-report-shows-76-4-increase-for-in-network-air-ambulance-costs.

34. Stephenson, *supra* note 32.

35. Ike Brannon & David Kemp, *The Potential Pitfalls of Combating Surprise Billing*, 42 CATO INST. REG., Fall 2019, at 40, https://www.cato.org/sites/cato.org/files/2019-10/regulation-v42n3-1-updated.pdf.

36. *Id.*

B. The Federal Government's Limited Regulation of Balance Billing

Before the enactment of the No Surprises Act, the federal government enacted some limited regulations to prevent balance billing in government-funded healthcare programs.[37] However, these federal regulations were limited in scope to services reimbursed by Medicaid and Medicare and failed to cover any commercial insurance products or employer health plans.[38] For instance, Section 1396a(n)(3)(A) of the Social Security Act explicitly states that the amount of money paid under a state healthcare plan, such as Medicaid, "shall be considered to be payment in full for the service."[39] Also, the beneficiary "shall not have any legal liability to make payment to a provider or to an organization . . . ."[40] Therefore, with regard to Medicaid, providers cannot balance bill beneficiaries "if the providers have already billed and accepted payment from Medicaid."[41]

Similarly, under Medicare, participating providers cannot balance bill beneficiaries because these providers agreed to accept Medicare's approved payment amounts as full payment for the services rendered to the beneficiary.[42] Furthermore, 42 U.S.C. § 1396a(a)(25)(C) explicitly states that when a person is entitled to medical assistance under a state plan, the provider "furnishing the service may not seek to collect from the individual . . . payment of an amount for that service."[43] However, nonparticipating providers can balance bill, but they can only do so in a limited capacity.[44] Pursuant to 42 U.S.C. § 1395w-4(a)(2)(D)(3), nonparticipating providers' "payment[s] shall be based on 95 percent of the payment basis for such services furnished by a participating" provider.[45] Nonparticipating providers can then bill Medicare beneficiaries a "limiting charge," meaning that they cannot charge the beneficiaries more than fifteen percent of what Medicare would pay to the provider.[46]

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37. WEN SHEN, BALANCE BILLING: CURRENT LEGAL LANDSCAPE AND PROPOSED FEDERAL SOLUTIONS, CONG. RES. RES. 2 (2019), https://sgp.fas.org/crs/misc/LSB10284.pdf.

38. *Id.*

39. 42 U.S.C. § 1396(n)(3)(A) (2020).

40. *Id.* at § 1396(n)(3)(B).

41. SHEN, *supra* note 37, at 2.

42. *Id.*

43. 42 U.S.C. § 1396a(a)(25)(C).

44. MEDICARE RESOURCES CTR., *What Is Balance Billing?*, https://www.medicareresources.org/glossary/balance-billing/ (last visited Nov. 15, 2020).

45. 42 U.S.C. § 1395w-4(a)(2)(D)(3) (2020).

46. MEDICARE RESOURCES CTR., *supra* note 44.

When it comes to Medicare and Medicaid, as exhibited by the several statutes in place, the federal government aims to eliminate balance billing in its entirety or reduce its reach,[47] and it imposes sanctions on those who violate balance billing statutes.[48] However, until the enactment of the No Surprises Act, there were no federal laws to address balance billing in the context of private insurance.[49] As a result, state governments took it upon themselves to develop balance billing regulations to protect their residents who obtain healthcare coverage from the private insurance market.[50]

C. State Solutions to Balance Billing Issues in the Private Insurance Market

As of February 5, 2021, thirty-three states offer some form of regulation in order to protect their residents against balance billing in the private insurance market.[51] However, while the majority of states have laws to combat balance billing, certain states have more comprehensive balance billing solutions than others.[52] The Commonwealth Fund, a respected private foundation developed to achieve better access and improved quality and efficiency in the healthcare system for society's most vulnerable, established four factors to evaluate whether state balance billing regulations meet the standards for comprehensive protection.[53] To be considered "comprehensive," the regulations should (1) "[e]xtend protections to both emergency department and in-network hospital settings," (2) apply to all types of insurance, including both Health Maintenance Organizations (HMOs) and Preferred Provider Organizations (PPOs), (3) protect consumers both by holding them harmless from extra provider charges and prohibiting

47. 42 U.S.C. §§ 1395-w4(a)(2)-(3), 1396a(n)(3)(A)–(B).

48. Memorandum, Melanie Bella, Dir., Medicare-Medicaid Coordination Office, Cindy Mann, Dir., CMCS, on Billing for Services Provided to Qualified Medicare Beneficiaries (QMBs) 2 (Jan. 6, 2012), https://www.medicaid.gov/federal-policy-guidance/downloads/cib-01-06-12.pdf.

49. SHEN, *supra* note 37, at 2.

50. *Id.* at 3.

51. Maanasa Kona, *State Balance-Billing Protections*, COMMONWEALTH FUND fig.1 (Feb. 5, 2021), https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

52. *See id.*; JACK HOADLEY & KEVIN LUCIA, UNEXPECTED CHARGES: WHAT STATES ARE DOING ABOUT BALANCE BILLING, CAL. HEALTHCARE FOUND. 13 (2009), https://www.chcf.org/wp-content/uploads/2017/12/PDF-UnexpectedChargesStatesAndBalanceBilling.pdf.

53. COMMONWEALTH FUND, *About Us*, https://www.commonwealthfund.org/about-us (last visited Mar. 21, 2021); Jack Hoadley et al., *State Efforts to Protect Consumers Against Balance Billing*, COMMONWEALTH FUND (Jan. 18, 2019), https://www.commonwealthfund.org/blog/2019/state-efforts-protect-consumers-balance-billing. [hereinafter Hoadley et al., *State Efforts to Protect Consumers*].

providers from balance billing, and (4) adopt an adequate payment standard or a dispute resolution process to resolve payment disputes between providers and insurers.[54] At the time of this writing, fifteen states have enacted comprehensive balance billing regulations that satisfy all four of the Commonwealth Fund factors.[55]

However, it must be noted that labeling regulations as "comprehensive" does not necessarily imply that patients receive "total protection" from balance billing.[56] But, when considering the factors together, they protect patients in most emergency department and in-network hospital settings.[57]

1. Factor One: Protection in Both Emergency and In-Network Hopsital Settings

The first factor for evaluating whether a balance billing regulation is comprehensive - protecting patients from balance billing in both emergency situations and in-network hospital visits - is paramount. In 2017, eighteen percent of emergency visits and sixteen percent of inpatient hospital stays resulted in a surprise bill.[58] Illinois has one of the most comprehensive balance billing regulations, especially in terms of satisfying factor one.[59] The Illinois Balance Billing Law enacted in 2011 reads as follows:

> When a beneficiary . . . utilizes a participating network hospital or a participating network ambulatory surgery center and, due to any reason, in network services for radiology, anesthesiology, pathology, [or] emergency physician . . . are unavailable and are provided by a nonparticipating facility-based physician or provider, the insurer . . . shall ensure that the beneficiary . . . shall incur no greater out-of-pocket costs than the beneficiary . . . would have incurred with a participating physician or provider for covered services.[60]

Therefore, Illinois balance billing regulations cover both services performed by emergency room physicians as well as services that may

54. Jack Hoadley, Professor, Geo. U., State Approaches to Protecting Consumers from Surprise Medical Bills, Address Before the House Comm. on Educ. on Lab. 3–4 (Apr. 2, 2019), https://edlabor.house.gov/imo/media/doc/2019-04-02%20HELP%20Hearing%20Hoadley%20Testimony.pdf.

55. U.S. DEP'T OF HEALTH & HUMAN SERVS., HHS SECRETARY'S REPORT ON: ADDRESSING SURPRISE MEDICAL BILLING 13 (2020), https://aspe.hhs.gov/sites/default/files/migrated_legacy_files//196341/Surprise-Medical-Billing.pdf. The states are: California, Colorado, Connecticut, Florida, Illinois, Maryland, New Hampshire, New Jersey, New Mexico, New York, Oregon, Texas, and Washington. *Id.*

56. Hoadley, *supra* note 54, at 3–4.

57. *Id.*

58. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 55, at 6.

59. *Id.* at 13 n.36.

60. 215 ILL. COMP. STAT. 5/356z.3a(b) (2011).

be performed by other out-of-network providers at an in-network facility.[61] However, despite its comprehensive reach, the Illinois Balance Billing Law still fails to protect patients who are taken to emergency departments at non-network hospitals.[62] The wide reach of the Illinois statute nevertheless illustrates that states with comprehensive balance billing regulations still protect patients more than states with lesser regulations.[63]

2. Factor Two: Protection of Beneficiaries of All Types of Insurance Plans

Next, state regulations satisfy the second requirement for comprehensive balance billing protections if the regulations contemplate beneficiaries of all types of insurance plans.[64] However, in some states, the balance billing protections offered depend on whether a beneficiary has a PPO or HMO insurance plan.[65] Unlike PPO plans, HMOs require patients to get a referral from their primary care physician before seeking out other healthcare services.[66] For instance, in Colorado, the balance billing laws protect both HMO and PPO beneficiaries in the same way, meaning that neither beneficiary will be penalized for failing to pay a balance bill.[67] In contrast, Texas's balance billing laws offer greater protection to beneficiaries with HMO insurance plans.[68] For example, HMO beneficiaries are not liable for refusing to pay a balance bill in Texas.[69] On the other hand, insurers must only disclose to PPO beneficiaries the possibility that they will receive balance bills.[70] Therefore, the only protection afforded to these PPO beneficiaries in Texas is notice.[71] Similarly, Maryland only protects PPO beneficiaries from balance billing when their care involves on-call physicians and hospital-based physicians.[72]

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61. *Id.*
62. Hoadley, *supra* note 54, at 4.
63. *Id.*
64. *Id.* at 3–4.
65. Hoadley et al., *State Efforts to Protect Consumers*, *supra* note 53.
66. BLUE CROSS BLUE SHIELD MICH., *What's the Difference Between HMO and PPO Plans?*, https://www.bcbsm.com/index/health-insurance-help/faqs/topics/how-health-insurance-works/difference-hmo-ppo.html (last visited Nov. 15, 2020).
67. HOADLEY & LUCIA, *supra* note 52, at 7.
68. KEVIN LUCIA ET AL., BALANCE BILLING BY HEALTHCARE PROVIDERS: ASSESSING CONSUMER PROTECTIONS ACROSS STATES, COMMONWEALTH FUND 4 (2017), https://www.commonwealthfund.org/sites/default/files/documents/___media_files_publications_issue_brief_2017_jun_lucia_balance_billing_ib.pdf.
69. *Id.* at 6.
70. *Id.* at 4.
71. *See id.*
72. Hoadley et al., *State Efforts to Protect Consumers*, *supra* note 53, at n.(e).

3. Factor Three: Protection by Holding Patients Harmless and Prohibting Providers from Sending Balance Bills

The third factor in determining whether a balance billing regulation is comprehensive, the "hold harmless" standard, also varies from state to state.[73] The most comprehensive hold harmless provisions protect patients by not holding them responsible for extra provider charges while also prohibiting providers from balance billing in the first place.[74] California, for example, protects patients in both aspects.[75] On the other end of the spectrum, some states, like Colorado, only stipulate that patients do not have to pay balance bills, but the laws do not prevent providers from sending them.[76] However, since patients must be held harmless, managed care organizations must resolve the bill before a provider can pursue action against the beneficiary, thereby precluding balance bills.[77] Nevertheless, receiving unexpected bills can still confuse patients who are unfamiliar with state regulations that prevent them from having to pay the bill.[78]

Moreover, an additional consideration pertaining to the third factor is that some states do not protect patients from balance bills in the context of nonemergency settings if the patient provided his prior written consent to obtain services from an out-of-network provider. For instance, in New Mexico, balance billing regulations do not protect a patient if the patient gives "specific consent for that nonparticipating provider to render the particular services rendered."[79]

4. Factor Four: Protection through an Adequate Payment Standard or Dispute Resolution Process

Having regulations that (1) "extend protections to both emergency department and in-network hospital settings," (2) apply to all types of insurance, and (3) protect consumers both by holding them harmless from extra provider charges and prohibiting providers from balance billing is important in determining whether balance billing regulations

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73. *Id.*

74. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 55.

75. Hoadley, *supra* note 54, at 5.

76. HOADLEY & LUCIA, *supra* note 52, at 7.

77. *Id.*

78. Leah Selby Gray, *An Elegant Solution to Network Inadequacy: How to Better Protect Patients from Inadequate Health Networks and Surprise Balance Billing*, 70 HASTINGS L.J. 1639, 1658 (2019).

79. Surprise Billing Protection Act of 2019, S.B. 337, 54th Leg., 1st Sess., 2019 N.M. Laws ch. 227; Jack Hoadley et al., *States Are Taking New Steps to Protect Consumers from Balance Billing, But Federal Action Is Necessary to Fill Gaps*, COMMONWEALTH FUND (July 31, 2019), https://doi.org/10.26099/jfne-dp10 [Hoadley et al., *State Are Taking New Steps*].

are comprehensive.[80] However, the final and fourth factor, a clear state-defined reimbursement plan or dispute resolution process, encompasses "the path to a satisfactory solution."[81] When a patient receives healthcare services from an in-network provider, the provider and the patient's insurer have a contract, so the insurers pay the providers based on their contract.[82] With out-of-network providers, however, no contract exists and providers and insurance companies may frequently disagree over the payment.[83] Therefore, having a payment standard or dispute resolution process helps providers resolve billing issues without involving the patient. Furthermore, with a well-defined reimbursement standard or dispute resolution process, neither the provider nor insurer has excessive leverage over the other in negotiations.[84]

i. Enactment of a Payment Standard

To combat the reimbursement issue between out-of-network providers and insurance companies, some states have adopted a benchmark payment standard, meaning that the state provides a formula that the insurance company is required to apply when calculating the payment owed to an out-of-network provider.[85] With payment standards, there is no room for negotiation, so the provider must accept the amount.[86] However, there is no consensus amongst the states that have adopted a payment standard as to how payments should be calculated.[87] For instance, some states like California structure the payment standard as a percentage of Medicare rates.[88] In 2016, California passed a balance billing regulation which mandates insurance companies to pay out-of-network providers either "the greater of the average contracted rate or 125 percent of the amount that Medicare reimburses."[89] In theory, this approach should decrease providers' bargaining leverage and disincentivize providers from staying out-of-

80. Hoadley, *supra* note 54, at 3–4.

81. HOADLEY & LUCIA, *supra* note 52, at 10.

82. Hoadley, *supra* note 54, at 5.

83. *Id.*

84. *See id.*

85. Jack Hoadley et al., *Criteria for Meeting Standards*, COMMONWEALTH FUND (Jan. 18, 2019), https://www.commonwealthfund.org/sites/default/files/2019-01/Criteria_for_Meeting_Standards_v2.pdf [Hoadley et al., *Criteria for Meeting Standards*].

86. *See id.*

87. LUCIA ET AL., *supra* note 68, at 4.

88. Hoadley, *supra* note 54, at 5.

89. Gray, *supra* note 78, at 1656 (quoting CAL. HEALTH & SAFETY CODE § 1371.31(a)(1) (West 2019)).

network.[90] Many states also choose to use the Medicare fee schedule as their base since the value scale utilized by Medicare is relatively well-accepted and does not change based on the type or location of the physician performing the services.[91] In fact, America's Health Insurance Plans found that, as of July 2019, California saw an average sixteen percent increase in in-network providers in California commercial networks after the implementation of its payment standard in 2017.[92] On the other hand, states like Florida calculate their payment standard by viewing the "usual and customary provider charges for similar services in the community where the services were provided."[93] However, this is problematic because providers and insurers often dispute the standards used to determine usual and customary fees.[94] Therefore, while different approaches exist to determine the payment standard, the benchmark standard provides the most consistent calculation and helps prevent payment disputes between providers and insurers.

ii. Enactment of Dispute Resolution

On the other hand, states that opt for a dispute resolution process often require binding arbitration between the insurer and provider to determine the amount owed to the provider in balance billing cases.[95] New York, for example, through its independent dispute resolution (IDR) process enacted in 2014, requires insurers and healthcare providers to make their best offer, and then an independent arbiter decides which amount is the most reasonable.[96] This style of arbitration is referred to as "baseball-style" arbitration because it works the same way as Major League Baseball negotiations: the arbiter must ultimately pick one of the proposals rather than independently calculate the value of the claim.[97] Because the independent arbiter will inevitably have to choose one of the proposals, this approach encourages the insurers and healthcare providers to meet in the middle with regard to

90. Loren Adler et al., *California Saw Reduction in Out-of-Network Care from Affected Specialties After 2017 Surprise Billing Law*, BROOKINGS (Sept. 26, 2019), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/09/26/california-saw-reduction-in-out-of-network-care-from-affected-specialties-after-2017-surprise-billing-law/.

91. HOADLEY & LUCIA, *supra* note 52, at 10.

92. Adler et al. *supra* note 90.

93. HOADLEY & LUCIA, *supra* note 52, at 10.

94. *Id.*

95. Hoadley et al., *Criteria for Meeting Standards*, *supra* note 85.

96. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 55, at 23.

97. Brannon & Kemp, *supra* note 35, at 43.

the price.[98] Furthermore, the arbiter must consider certain factors when choosing a proposal, such as the fees paid by the healthcare plan to reimburse similarly qualified physicians for the same services in the same region, as well as the training, experience, and usual charge of the provider.[99] In New York, the disputed price must exceed $683.22 in order to trigger the dispute resolution process.[100] Between 2015 and 2018, New York reported that the balance billing regulations enacted in the state saved patients over $400,000,000 in emergency room service charges.[101] Such arbitration decisions in New York have not been shown to favor either the provider or insurer. In 2018, there were 561 disputes settled in favor of the healthcare provider and 618 disputes decided in favor of the insurer.[102]

Overall, California and New York's regulations exemplify the most comprehensive approaches to regulating balance billing practices. However, no matter how comprehensive state plans are, there are a few areas of balance billing that state law is barred from reforming.[103]

D. Areas in Which State Balance Billing Regulation Is Off-limits

First, federal law prohibits states from protecting patients against balance bills that result from air ambulance services.[104] This is because the federal Airline Deregulation Act (Airline Act) prevents states from enacting regulations involving certain aspects of air carriers.[105] For example, the Airline Act states that "a State . . . may not enact . . . a regulation . . . related to a price, route, or service, of an air carrier that may provide air transportation."[106] A study performed by the United States Government Accountability Office found that, in both 2012 and 2017, about two-thirds of the air ambulance transports for privately-insured patients were out-of-network.[107] Moreover, the bal-

98. *Id.*

99. SABRINA CORLETTE & OLIVIA HOPPE, NEW YORK'S 2014 LAW TO PROTECT CONSUMERS FROM SURPRISE OUT-OF-NETWORK BILLS MOSTLY WORKING AS INTENDED, ROBERT WOOD JOHNSON FOUND. 5 (2019), https://chirblog.org/wp-content/uploads/2020/02/Georgetown_State Based-NY-Billing_May2019.pdf.

100. Brannon & Kemp, *supra* note 35, at 44.

101. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 55, at 23.

102. CORLETTE & HOPPE, *supra* note 99, at 8.

103. Hoadley, *supra* note 54, at 5.; LUCIA ET AL., *supra* note 68, at 2.

104. Hoadley, *supra* note 54, at 5.

105. Sabrina Corlette & Maanasa Kona, *Lawmakers Had a Chance to Provide Relief from Surprise Medical Bills – and Whiffed It*, GEO. U. CTR. ON HEALTH INS. REFORMS (Sept. 27, 2018), http://chirblog.org/lawmakers-blow-chance-to-curb-surprise-medical-billing/.

106. 49 U.S.C. § 41713(b)(1) (1994).

107. . *See* U.S. GOV'T ACCOUNTABILITY OFFICE, AIR AMBULANCE: AVAILABLE DATA SHOW PRIVATELY-INSURED PATIENTS ARE AT FINANCIAL RISK 16 (2019), https://www.gao.gov/assets/gao-19-292.pdf.

ance bills for such out-of-network air ambulatory services averaged around $20,000.[108] This prohibition on regulating the costs of air ambulance services prevents states from enacting legislation to protect patients in certain emergency situations when they may be especially vulnerable.[109]

The second major area in which state law cannot regulate balance billing involves self-insured plans.[110] Since the enactment of the Employee Retirement and Income Security Act (ERISA) in 1974, the Department of Labor has had the sole ability to monitor and regulate self-insured employee benefit plans established by private sector employers.[111] About sixty-one percent of workers with employer-sponsored health insurance are enrolled in self-insured ERISA plans.[112] Therefore, even in states like California and New York with the most comprehensive balance billing regulations, [113] state law cannot protect patients insured through employee benefit plans.[114] As a result, the only solution to regulating balance billing in situations involving air ambulance or self-insured plans is federal regulation.[115]

Lastly, state balance billing regulations cannot fully protect patients who receive treatment from out-of-state providers.[116] Washington temporarily has a plan to hold patients harmless who receive a balance bill after seeking emergency care in a different state, but in doing so, the insurance provider will likely be responsible for the balance bill, a compromise that insurance companies will not be too eager to accept.[117] Therefore, just like with self-insured plans and air ambulance services, federal regulations are necessary to combat balance billing in interstate situations.[118]

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108. Erin C. Fuse Brown et al., *Out-of-Network Air Ambulance Bills: Prevalence, Magnitude, and Policy Solutions*, 98 MILBANK Q. 747, 748, 757 (2020).

109. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 55, at 7.

110. LUCIA ET AL., *supra* note 68, at 2.

111. U.S. DEP'T OF HEALTH & HUMAN SERVS., *supra* note 55, at 11.

112. *Id.*

113. Hoadley, *supra* note 54, at 5; CORLETTE & HOPPE, *supra* note 99, at 3; Barack D. Richman et al., *Battling the Chargemaster: A Simple Remedy to Balance Billing for Unavoidable Out-of-Network Care*, 23 AM. J. MANAGED CARE e100, e102 (2017).

114. Gray, *supra* note 78, at 1650.

115. Brown et al., *supra* note 108, at 748.

116. Hoadley et al., *State Are Taking New Steps*, *supra* note 79.

117. *Id.*

118. *Id.*

E. Recent Federal Proposals to Regulate Balance Billing in the Private Sector

The federal government has recognized that state balance billing regulations are lacking in certain areas and need urgent attention. To that end, several legislative committees have recently developed proposals to combat balance billing in the private insurance market.[119] In fact, actual balance billing legislation in the form of the No Surprises Act took effect on January 1, 2022.[120] This surprise balance billing legislation was part of the recent $900 billion COVID-19 relief package signed into law by President Trump on December 27, 2020.[121] Prior to the enactment of the No Surprises Act, two influential federal proposals, the Consumer Protections Against Medical Bills Act of 2020 (H.R. 5826) and the Ban Surprise Billing Act (H.R. 5800), were presented at the 116th United States Congress.[122] Although those bills have since died, they act as an effective tool for evaluating the No Surprises Act since each bill had a similar purpose. The No Surprises Act "adopts a comprehensive approach to protecting consumers from surprise medical bills."[123] Similarly, the Consumer Protections Against Medical Bills Act of 2020 pledged to "protect Americans from unexpected financial burdens when receiving health care."[124] The Ban Surprise Billing Act also claimed to be a "bipartisan solution that protects patients from unexpected, often significant out-of-pocket costs while being fair to both providers and payers."[125] However, despite having nearly the same purpose, each bill differs significantly in key aspects. For instance, while the Ban Surprise Billing Act and the No Surprises Act offer protection against balance billing in the con-

119. Press Release, Comm. On Educ. & Lab. Republicans, Comm. Advances Bipartisan Solution to Ban Surprise Billing (Feb. 11, 2020), https://republicans-edlabor.house.gov/news/documentsingle.aspx?DocumentID=406879; Rachel Stauffer & Katie Waldo, *Surprise Billing Background and Comparison*, McDermott Plus (Feb. 25, 2020), https://www.mcdermottplus.com/insights/surprise-billing-background-and-comparison-updated-feb-2020/.

120. Ctrs. For Medicare & Medicaid Servs., *Surprise Billing & Protection* (Jan. 14, 2022), https://www.cms.gov/nosurprises/Ending-Surprise-Medical-Bills.

121. Emily Boerger, *Congress Passes Surprise Medical Billing Fix*, St. Reform (Dec. 22, 2020), https://stateofreform.com/federal/2020/12/congress-passes-surprise-medical-billing-fix/; Jack Hoadley et al., *Unpacking the No Surprises Act: An Opportunity to Protect Millions*, Health Affs. (Dec. 18, 2020), https://www.healthaffairs.org/do/10.1377/hblog20201217.247010/full/ [Hoadley et al., *Unpacking the No Surprises Act*].

122. Press Release, Ways & Means Comm., Neal and Brady Release Legislative Text of Surprise Medical Billing Proposal (Feb. 7, 2020), https://waysandmeans.house.gov/media-center/press-releases/neal-and-brady-release-legislative-text-surprise-medical-billing; Press Release, Comm. on Educ. & Labor Republicans, *supra* note 119.

123. Hoadley et al., *Unpacking the No Surprises Act*, *supra* note 121.

124. Press Release, Ways & Means Comm., *supra* note 122.

125. Press Release, Comm. On Educ. & Labor, *supra* note 119.

text of air ambulance services, the Consumer Protections against Surprise Medical Bills Act of 2020 failed to do so.[126] Therefore, analyzing each bill's provisions provides insight as to whether Congress chose the most comprehensive balance billing legislation to include in its COVID-19 relief package. On February 7, 2020, the Ways and Means Committee of the federal government released the official legislative text of the Consumer Protections Against Surprise Medical Bills Act of 2020.[127] The introduction of this bill explicitly states that the bill existed to "prevent certain cases of out of-network surprise medical bills, strengthen health care consumer protections, and improve health care information transparency . . . ."[128]

Quite conveniently, just a few days later on February 11, 2020, the Committee on Education and Labor advanced the Ban Surprise Billing Act.[129] Representative Foxx (R), one of the sponsors of the Ban Surprise Billing Act, indicated that this bill was designed to give patients "financial confidence" and to "shield American families from financially devastating surprise medical bills."[130] The No Surprises Act, which would ultimately garner the most support, was actually introduced on January 3, 2019 and was advanced by both the Committees on Energy and Commerce and Education and Labor.[131] The No Surprises Act has the general purpose of "protect[ing] health care consumers from surprise billing practices."[132] The No Surprises Act had seemingly lost traction in Congress until the COVID-19 pandemic reengaged lawmakers' attention after the increase in surprise medical bills and the simultaneous impact on Americans' ability to pay these unexpected costs.[133] As a result, the No Surprises Act became part of the Consolidated Appropriations Act, 2021.[134]

In summary, prior to the enactment of the No Surprises Act, federal balance billing regulations only governed services rendered under

126. Ban Surprise Billing Act, H.R. 5800, 116th Cong. § 2(f)(1) (2020); No Surprises Act, H.R. 3630, 116th Cong. § 5(a) (2020); Consumer Protections Against Surprise Medical Bills Act of 2020, H.R. 5826, 116th Cong. § 1(b) (2020).

127. Press Release, Ways & Means Comm., *supra* note 122.

128. H.R. 5826, 116th Cong.

129. Press Release, Comm. On Educ. & Labor, *supra* note 119.

130. *Id.*

131. H.R. 3630, 116th Cong.

132. *Id.*

133. Matthew J. Goldman & Theresa E. Thompson, *No Surprises Act Comes as a Surprise – Consolidated Appropriations Act Includes New Restrictions on Surprise Bills*, 11 NAT'L L. REV., Jan. 4, 2021, https://www.natlawreview.com/article/no-surprises-act-comes-surprise-consolidated-appropriations-act-includes-new.

134. H.R. 133, 116th Cong. 2020.

Medicare and Medicaid.[135] While some states have tried to fill the gaps in federal balance billing legislation by regulating balance billing in the private sector,[136] the comprehensiveness of these regulations varies between states.[137]

Therefore, to determine whether either of the three recent federal proposals to regulate balance billing would have been effective, each bill must be analyzed in terms of the four factors encompassing "comprehensive balance billing legislation" described in Part II.[138] The federal bills must also be evaluated in terms of how effectively they regulate the specific areas that state balance billing regulations cannot reach, namely air ambulance service charges and self-insured plans. Lastly, the No Surprises Act will be analyzed in the context of the four comprehensive factors and reviewed against the other surprise billing proposals to determine whether the No Surprises Act achieves comprehensive balance billing protections or whether Congress should consider enacting one of the other proposals in the future to achieve the goal of comprehensive balance billing protection. [139] Finally, this Comment will explore the obstacles that the No Surprises Act may face after its enactment.[140]

III. Analysis

The Consumer Protections Against Surprise Medical Bills Act of 2020 (H.R. 5826), the Ban Surprise Billing Act (H.R. 5800), and the No Surprises Act (H.R. 3630) all represent solutions to the issues associated with balance billing.[141] Consequently, in order to be deemed adequate, each bill must satisfy the four factors that constitute comprehensive balance billing regulation.[142] Additionally, in order to be considered comprehensive, each federal proposal must offer sufficient protection for users of air-ambulance services and those insured under

135. Shen, *supra* note 37, at 2.

136. Hoadley & Lucia, *supra* note 52, at 13.

137. *Id.* To reiterate, in order to be considered comprehensive, the regulations must generally satisfy four factors: (1) extending protections to both emergency department and in-network hospital settings, (2) applying laws to all types of insurance, including both HMOs and PPOs, (3) protecting consumers both by holding them harmless from extra provider charges and prohibiting providers from balance billing, and (4) adopting an adequate payment standard or a dispute resolution process to resolve payment disputes between providers and insurers. Hoadley, *supra* note 54, at 4.

138. *See supra* Part II.E.

139. H.R. 5800, 116th Cong.; H.R. 5826, 116th Cong.

140. Clement, *supra* note 21, at 2–3.

141. *See infra* Part III; H.R. 5800, 116th Cong.; H.R. 3630, 116th Cong.; H.R. 5826, 116th Cong.

142. *See infra* Part III.

ERISA plans, the two main areas that state regulations cannot reach.[143] Lastly, since the federal government ultimately chose the No Surprises Act, it is necessary to evaluate whether the federal government made the appropriate decision or whether it should have chosen one of the other balance billing proposals instead.[144]

A. The Consumer Protections Against Surprise Medical Bills Act of 2020

In terms of factor one, extending protection to emergency and in-network hospital visits, the Consumer Protections Against Surprise Medical Bills Act of 2020 (Consumer Protections Medical Bills Act) promised to prohibit balance billing for all emergency services.[145] In fact, the Consumer Protections Medical Bills Act explicitly stated that the "cost-sharing requirement [for emergency services will not be] greater than the requirement that would apply if such services were furnished by a participating provider or a participating emergency facility."[146] Therefore, the Consumer Protections Medical Bills Act solved the problem of balance billing for emergency services at non-network facilities that Illinois's comprehensive regulations left unaddressed.[147] Consequently, in the realm of emergency medical care, this bill offered more protection than already existing comprehensive state balance billing regulations.[148] Similarly, with regard to non-emergency care provided by out-of-network providers at in-network facilities, the patient would only be responsible for the in-network rate.[149] In addition to services provided by standard physicians, ancillary services provided by out-of-network physicians such as anesthesiologists or radiologists would be calculated at the in-network rate as well.[150] Therefore, the Consumer Protections Medical Bills Act fully protected patients seeking emergency and non-emergency services, satisfying the first factor of comprehensive balance billing regulation.[151]

However, a major caveat existed when it came to nonparticipating providers in non-emergency situations.[152] If the nonparticipating provider gave the patient notice that he was an out-of-network provider

143. *Id.*
144. *Id.*
145. H.R. 5826, 116th Cong. § 2(a).
146. *Id.* at § 2(a)(1)(A)(III)(ii).
147. *Id.*; *see* 215 ILL. COMP. STAT. 5/356z.3a (2011).
148. § 5/356z.3a.
149. Stauffer & Waldo, *supra* note 119.
150. *Id.*; Murphy, *supra* note 12.
151. Hoadley, *supra* note 54, at 4.
152. H.R. 5826, 116th Cong § 1150C(b)(2)(A) (2020).

forty-eight hours prior to rendering medical services or on the day on which the patient obtained the appointment for such services and the patient provided his consent, the patient would be responsible for higher cost-sharing obligations.[153] Although this process favored the provider since a patient may not have the opportunity to find a participating provider in time to obtain the services he may desperately need after receiving said notice, it inevitably eliminated the "surprise" factor that characterizes balance billing.[154] Patients may not be pleased to know that their insurance will not cover their entire treatment, but at least with the notice and consent requirement, they could brace themselves for the payment to come.[155]

Next, in order to satisfy factor two, balance billing regulations must apply to all types of insurance, protecting both HMO and PPO beneficiaries as well as members of self-insured plans.[156] The Consumer Protections Medical Bills Act complied with factor two because this bill did not differentiate balance billing protection based on the patient's type of insurance plan.[157] It can be inferred that the Consumer Protections Medical Bills Act intentionally did not make a distinction based on plan type in order to incorporate self-insured plans that ERISA does not allow states to regulate.[158] Essentially, if the Consumer Protections Medical Bills Act did not protect people with self-insured plans, it would not satisfy factor two because it would be failing to protect an entire sect of people that state laws legally cannot safeguard.[159] However, because the Consumer Protections Medical Bills Act seemed to offer protections to people with self-insured plans, this bill satisfied factor two.[160]

Furthermore, the Consumer Protections Medical Bills Act also satisfied factor three, the hold harmless provision, by committing to not only hold patients harmless from surprise medical bills, but also by prohibiting providers from sending such bills in the first place.[161] The Consumer Protections Medical Bills Act explicitly states that an "emergency department shall not bill, and shall not hold liable, the individual for a payment amount for such emergency services so fur-

153. *Id.*

154. *Id.*

155. *Id.*

156. Hoadley, *supra* note 54, at 4, 6.

157. H.R. 5826 § 1.

158. Not allowing protections for self-insured plans would essentially defeat one of the main purposes of federal balance billing regulations.

159. Hoadley, *supra* note 54, at 6.

160. *See generally* H.R. 5826; Hoadley, *supra* note 54, at 4.

161. H.R. 5826 § 1150C(a)(1).

nished that is more than the cost-sharing amount for such services."[162] The phrases "shall not bill" and "shall not hold liable" illustrate that providers would be forbidden from balance billing and that patients would also be held harmless for not paying such bills.[163] The same held true for out-of-network providers since "a nonparticipating provider . . . shall not bill, and shall not hold liable, such individual for a payment amount . . . that is more than the cost-sharing amount."[164] Consequently, in the context of both emergency and nonemergency services, the Consumer Protections Medical Bills Act fully protected patients from balance bills.[165]

Lastly, the Consumer Protections Medical Bills Act fulfilled the fourth and final factor of comprehensive balance billing, providing an adequate payment standard or dispute resolution process, because this bill adopted a clear payment dispute resolution procedure.[166] Although the Consumer Protections Medical Bills Act did not include a payment standard, this did not preclude the bill from being considered "comprehensive" because having a dispute resolution procedure alone is sufficient to satisfy the fourth factor.[167] However, unlike New York's dispute resolution process, the solution proposed by the Consumer Protections Medical Bills Act did not set a minimum billing amount that must exist before triggering the arbitration process.[168] Without a minimum, the arbitration process that works so well in New York would not act as efficiently at the federal level since the lack of a minimum threshold increases the risk of constant arbitration for minimal payment amounts.[169] As a result, it would take a while for arbiters to become available for providers and insurers who actually need arbitration to decide more significant payment disputes.[170] Nevertheless, the payments that the arbiter ultimately agreed on would have likely been quite accurate since the Consumer Protections Medical Bills Act prevented arbiters from considering usual and customary charges, a more subjective approach, when deciding the payment owed.[171] As a result, the Consumer Protections Medical Bills Act did, in fact, meet

162. *Id.*

163. *Id.*

164. *Id.*

165. *Id.*; Hoadley, *supra* note 54, at 4.

166. H.R. 5826 § 1150C(b)(1).

167. Hoadley, *supra* note 54, at 4.

168. Brannon & Kemp, *supra* note 35, at 43; Stauffer & Waldo, *supra* note 119.

169. Brannon & Kemp, *supra* note 35, at 43.

170. *Id.* ("Without [a minimum threshold], providers and insurers would be able to abuse IDR in trivial disagreements.").

171. *Id.*

factor four despite potential issues that would possibly arise once its dispute resolution process was enacted.[172]

Although the Consumer Protections Medical Bills Act coincided with the four comprehensive balance billing factors, it failed to shield patients from one major area of balance billing to which federal balance billing regulations should apply: air ambulance services.[173] Instead of providing air ambulance protections, the Consumer Protections Medical Bills Act simply called for more transparency in health plans.[174] Transparency, however, is not enough since the average consumer may not have the specialized skillset to understand insurance rate breakdowns and may not be able to evaluate his insurance plan when facing life or death situations.[175] For instance, the Consumer Protections Medical Bills Act required health plans to include information about out-of-network deductibles and cost-sharing obligations for emergency services so that the patients would be informed about payment amounts.[176] However, state regulations can just as easily include these transparency plans in their balance billing laws since nothing in state or federal law prevents them from doing so, which is not the case with air ambulance regulations.[177]

Therefore, the proposed Consumer Protections Medical Bills Act was overall lacking and rather weak because it essentially mirrored the most comprehensive state plans and failed to fill many of the gaps which are within the federal government's exclusive power to regulate.[178] There is no need for the federal government to provide balance billing regulations that states are capable of enacting themselves. The purpose of the federal plans should be to regulate areas outside of the states' reach.[179] However, aside from the inclusion of beneficiaries of self-insured plans in the proposal, the Consumer Protections Medical Bills Act failed to offer enough extra protections to make this proposal more attractive than a comprehensive state plan.[180] For this

172. Hoadley, *supra* note 54, at 4.

173. *Id.*

174. H.R. 5826, 116th Cong. § 5 (2020).

175. *See* ROBERT WOOD JOHNSON FOUND., *How Price Transparency Can Control the Cost of Health Care* (Mar. 1, 2016), https://www.rwjf.org/en/library/research/2016/03/how-price-transparency-controls-health-care-cost.html.

176. MCDERMOTT PLUS, *Details of the Major Surprise Billing Proposals* (Feb. 25, 2020), https://www.mcdermottplus.com/wp-content/uploads/2020/03/Details-of-the-Major-Surprise-Billing-Proposals-Chart-2020.pdf.

177. 49 U.S.C. § 41713(b)(1) (1994).

178. Hoadley, *supra* note 54, at 4.

179. LUCIA ET AL., *supra* note 68, at 7.

180. H.R. 5826, 116th Cong. § 1(b) (2020).

reason, the federal government made the proper decision in not taking action on the Consumer Protections Medical Bills Act.[181]

B. The Ban Surprise Billing Act

Despite the inadequacy of the Consumer Protections Medical Bills Act, the Ban Surprise Billing Act still had potential.[182] Like the Consumer Protections Medical Bills Act, the Ban Surprise Billing Act also offered protection against balance billing for all emergency services.[183] The Ban Surprise Billing Act explicitly states that the insurer shall cover emergency services "whether the health care provider furnishing such services is a participating provider or a participating emergency facility."[184] Unlike comprehensive state laws like those in Illinois, the Ban Surprise Billing Act's language indicated that non-network emergency departments would also be included in balance billing regulations.[185] For example, the regulation covered services that "are provided to a participant or beneficiary by a nonparticipating provider or a nonparticipating emergency facility."[186] Furthermore, with regard to non-emergency services, the Ban Surprise Billing Act also limited the cost-sharing amount to the amount that "would apply under such plan or coverage, respectively, had such items or services been furnished by a participating provider."[187] Although the same notice and consent caveat that existed for the Consumer Protections Medical Bills Act was also contained in the Ban Surprise Billing Act,[188] the Ban Surprise Billing Act still satisfied factor one just like the Consumer Protections Medical Bills Act because it prohibited balance billing patients in emergency settings and when receiving treatment from out-of-network providers at in-network facilities.[189]

With regard to factor two, applying laws to all types of insurance, the Ban Surprise Billing Act did not appear to make a distinction regarding protection based on the type of insurance plan a patient had, indicating that this bill would also protect patients with self-insured ERISA plans against balance billing like the Consumer Protections

181. *See* CONGRESS.GOV, *All Actions H.R. 5826–116th Congress (2019-2020)*, https://www.congress.gov/bill/116th-congress/house-bill/5826/all-actions (last visited Apr. 24, 2022).

182. H.R. 5800 offers broader protections than H.R. 5826 that will be explored more in depth in Part III.B.

183. MCDERMOTT PLUS, *supra* note 176.

184. H.R. 5800, 116th Cong. § 716(b)(1)(B) (2020).

185. *Id.* § 716(b)(1)(C).

186. *Id.*

187. *Id.* § 716(e)(1)(A).

188. *Id.* § 2799A-2(d)(1).

189. MCDERMOTT PLUS, *supra* note 176.

Medical Bills Act.[190] Therefore, the Ban Surprise Billing Act satisfied factor two as well.[191]

However, an issue arose when evaluating the Ban Surprise Billing Act in terms of factor three, the hold harmless provision, particularly regarding emergency service providers.[192] This bill protected patients receiving treatment from nonparticipating, nonemergency providers to the fullest extent.[193] For instance, the bill explicitly stated that nonparticipating providers "shall not bill, and shall not hold liable such . . . beneficiary . . . for a payment amount . . . that is more than the cost-sharing amount for such item or service."[194] Therefore, this bill fulfilled the standard for comprehensive coverage regarding nonparticipating providers in nonemergency settings.[195] Under the Ban Surprise Billing Act, those who visit the hospital to have a scheduled surgery, for example, and interact with an out-of-network anesthesiologist, would not have to worry about paying balance bills because these providers would legally be prohibited from sending them in the first place.[196]

There would still be concern regarding the overall level of protection offered to patients who received emergency services under the Ban Surprise Billing Act, based on the text of the legislation.[197] While the Ban Surprise Billing Act forbade participating providers from balance billing in nonemergency settings,[198] it imposed no such prohibitions on nonparticipating providers who rendered emergency care.[199] Just like the provision regarding nonparticipating providers at in-network facilitates, this bill explicitly stated that an emergency provider or department "shall not hold the . . . beneficiary . . . liable for a payment amount . . . that is more than the cost-sharing amount for such services."[200] Although the language indicated that patients would not be penalized for failing to pay a surprise bill in the context of an emergency, there was no penalty if providers chose to send these patients balance bills anyway.[201] Therefore, in some instances, these providers would still succeed in receiving a payment on a balance bill if an un-

190. H.R. 5800 § 2(b)(1).
191. *Id.*; Hoadley, *supra* note 54, at 4.
192. H.R. 5800 § 2799A-1(a)(1).
193. *Id.* § 2799A-2(a).
194. *Id.*
195. Hoadley, *supra* note 54, at 4.
196. H.R. 5800 § 2799A-2(a).
197. *Id.* § 2799A-1(a)(1).
198. *Id.* § 2799A-2(a).
199. *Id.* § 2799A-1(a)(1).
200. *Id.* § 2799A-1(a)(2).
201. *Id.*

knowing patient, in fear of becoming past due on a bill and unaware of his rights, panicked and paid the bill. As a result, the Ban Surprise Billing Act did not meet the criteria required to satisfy factor three.[202] However, the thorough method in which the Ban Surprise Billing Act planned to resolve payment disputes as well as the additional protections it afforded made up for its mildly inadequate standard of provider liability.[203]

Although only one solution to resolving payment disputes is necessary to deem balance billing regulations comprehensive,[204] the Ban Surprise Billing Act included both mechanisms in its proposal.[205] First, the Ban Surprise Billing Act included a benchmark payment standard that providers and insurers must use for payment disputes amounting to less than $750.[206] By forcing entities to utilize a payment standard when the amount of money at issue is relatively small, arbitration would not be wasted on minuscule amounts.[207] Furthermore, there would be more arbiters available in situations where arbitration is actually necessary, such as when there are larger amounts in dispute and the entities require a third party's evaluation.[208] Moreover, the Ban Surprise Billing Act required as the payment standard a "market-based benchmark of the median in-network rate."[209] Therefore, the Ban Surprise Billing Act got rid of the usual and customary provider charges that some states like Florida use in favor of a more reliable formula to ensure greater accuracy when calculating the payments actually owed.[210]

In addition to the benchmark payment standard, the Ban Surprise Billing Act included an IDR process that would allow arbitration when the amount in dispute exceeded $750.[211] This process essentially mirrored the baseball-style arbitration process adopted in New York.[212] Because the baseball-style of arbitration has shown success and has proved to be an unbiased approach for resolving disputes in New York, there is no reason to doubt that this process would work any differently at the federal level.[213] Therefore, since the Ban Sur-

202. Hoadley, *supra* note 54, at 4.
203. H.R. 5800 §§ 4, 2799A-4.
204. Hoadley, *supra* note 54, at 4.
205. H.R. 5800 § 4(b)(2)(A), (d).
206. *Id.* § 4(b)(2)(A).
207. Brannon & Kemp, *supra* note 35, at 43–44.
208. *Id.*
209. Press Release, Comm. on Educ. & Labor Republicans, *supra* note 119.
210. H.R. 5800 § 716(b)(2)(E); HOADLEY & LUCIA, *supra* note 52, at 10.
211. H.R. 5800 § 4(b)(2)(A).
212. Brannon & Kemp, *supra* note 35, at 44.
213. *Id.*

prise Billing Act gave providers and insurers multiple options to resolve payment disputes, it undoubtedly exceeeded the factor four requirements for comprehensive balance billing regulations.[214]

Furthermore, the Ban Surprise Billing Act extensively protected air ambulance services – an area which the Consumer Protections Medical Bills Act disregarded.[215] Specifically, the Ban Surprise Billing Act states that in the case of a beneficiary who is furnished air ambulance services from a nonparticipating provider, "such provider shall not bill, and shall not hold liable, such participant, beneficiary."[216] Therefore, not only would patients receiving air ambulance services not have to pay a balance bill, the Ban Surprise Billing Act would prohibit air ambulance providers from sending these patients balance bills in the first place.[217] This section of the Ban Surprise Billing Act thus further satisfied factor three.[218] Furthermore, even though most people would not be able to pay an air ambulance bill, the fact that the Ban Surprise Billing Act prevented providers from sending bills in this context would eliminate any added stress and confusion that a person who had just gone through a traumatic, life-threatening situation would likely experience from receiving such a costly bill.[219]

The Ban Surprise Billing Act overwhelmingly met the criteria required to characterize it as a comprehensive balance billing regulation.[220] Although providers retained the ability to balance bill for emergency services,[221] the protections the Ban Surprise Billing Act offered were more than sufficient given that it also restricted the ability of air ambulance providers to balance bill patients. In order to be considered comprehensive, a federal proposal must exceed the protections already offered by state balance billing regulations, and the Ban Surprise Billing Act delivered.[222] Not only did the Ban Surprise Billing Act offer extensive protection for beneficiaries of self-insured plans,[223] but it also prevented balance billing in the context of air ambulance services,[224] an action that the Consumer Protections Medical

214. Hoadley, *supra* note 54, at 4.

215. H.R. 5800 § 2799A-4.

216. *Id.*

217. *Id.*

218. Hoadley, *supra* note 54, at 4.

219. Receiving a surprise medical bill would stress out any reasonable person.

220. Hoadley, *supra* note 54, at 4.

221. H.R. 5800 § 2799A-1(a)(2).

222. LUCIA ET AL., *supra* note 68, at 7.

223. *See generally* H.R. 5800.

224. *Id.* § 2799A-4.

Bills Act failed to take.[225] On its face, the Ban Surprise Billing Act seemed worth pursuing. However, Congress ultimately chose to enact the No Surprises Act.[226] Therefore, to determine whether Congress made the proper decision in choosing to enact the No Surprises Act over the Ban Surprise Billing Act, it is necessary to analyze the No Surprises Act as well.

C. The No Surprises Act

Despite the comprehensive character of the Ban Surprise Billing Act, Congress nevertheless chose to incorporate the No Surprises Act into the Consolidated Appropriations Act, 2021, and in doing so, Congress made the correct choice since the No Surprises Act satisfies all the necessary factors that make federal balance billing legislation comprehensive.[227] In terms of the first factor regarding the extension of balance billing protections in emergency and in-network hospital settings,[228] the No Surprises Act successfully meets the criteria. First of all, with regard to emergency services, the No Surprises Act specifically indicates that nonparticipating emergency providers or facilities must not impose "coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities."[229] Therefore, the No Surprises Act protects individuals obtaining emergency care not only from receiving balance bills from out-of-network emergency physicians at in-network facilities, but also from out-of-network facilities in general.[230] Similarly, with regard to nonemergency care, out-of-network providers must "not impose on such . . . beneficiary . . . a cost-sharing requirement . . . greater than the cost-sharing requirement that would apply under such plan or coverage."[231] Therefore, in terms of emergency and nonemergency care, the No Surprises Act satisfies factor one on the comprehensiveness scale.[232] Although a notice and consent provision exists that would allow nonparticipating providers to balance bill their patients,[233] this provision is standard as illustrated by its existence in both the Con-

225. H.R. 5826, 116th Cong. § 10(a)(2)(A) (2020) (only mentioning reporting requirements regarding air ambulance services).

226. Hoadley et al., *Unpacking the No Surprises Act*, *supra* note 121.

227. Hoadley, *supra* note 54, at 3–4; Brown et al., *supra* note 108, at 748.

228. Hoadley, *supra* note 54, at 3–4.

229. H.R. 133, 116th Cong. § 2799A-1(a)(1)(C)(i) (2020).

230. *Id.*

231. *Id.* § 2799A-1(b)(1)(A).

232. Hoadley, *supra* note 54, at 3.

233. H.R. 133 § 2799A-1(b)(1)(A).

sumer Protections Medical Bills Act and the Ban Surprise Billing Act[234] and therefore, should not impact whether the No Surprises Act meets the criteria for factor one.

Next, in terms of the second factor, having the regulations apply to all types of insurance, not only does the No Surprises Act make no distinction regarding protections for HMOs or PPOs, but the No Surprises Act also explicitly includes coverage for self-insured ERISA plans, something that the Consumer Protections Medical Bills Act and the Ban Surprise Billing Act failed to do.[235] Similar to the protections offered in factor one, the No Surprises Act will amend ERISA so that if a "health insurance issuer offering group health insurance coverage, provides or covers any benefits with respect to services in an emergency department . . . the . . . issuer shall cover emergency services."[236] Similarly, if a group health plan or health insurance issuer offers coverage furnished by a nonparticipating provider, the plan must "not impose on [the] participant or beneficiary a cost-sharing requirement . . . that is greater than the cost-sharing requirement that would apply . . . had such items or services been furnished by a participating provider."[237] Consequently, the No Surprises Act more thoroughly satisfies factor two than the Consumer Protections Medical Bills Act and the Ban Surprise Billing Act because instead of having to assume that self-insured plans are protected from balance billing, the No Surprises Act explicitly guarantees that those who have coverage under self-insured plans are protected.[238] Therefore, in terms of factor two, Congress made the right decision by including the No Surprises Act in the Consolidated Appropriations Act, 2021 over the other surprise billing proposals.

Furthermore, the No Surprises Act also offers the most complete protections in terms of holding individuals harmless who may be susceptible to balance billing, thereby satisfying factor three as well. With regard to both emergency care and out-of-network care performed by nonparticipating providers, the No Surprises Act holds beneficiaries harmless and prohibits providers from sending balance bills in the first place.[239] The No Surprises Act specifically states that nonparticipating

234. Stauffer & Waldo, *supra* note 119.

235. H.R. 133 § 102(b); *see infra* Part III.A–B.

236. H.R. 133 § 2799A-1.

237. *Id.* § 2799A-1(b)(1)

238. *Id.* § 102(b).

239. Press Release, House Comm. on Energy and Commerce, Congressional Committee Leaders Announce Surprise Billing Agreement (Dec. 11, 2020), https://energycommerce.house.gov/sites/democrats.energycommerce.house.gov/files/documents/No%20Surprise%20Act%20Section-by-Section%2012-11-20.pdf.

emergency departments and providers "shall not bill, and shall not hold liable" beneficiaries.[240] The same language is used for out-of-network providers delivering nonemergency care as well.[241] Because the Ban Surprise Billing Act did not prohibit providers from sending balance bills in the context of emergency care, the No Surprises Act undoubtedly surpasses the Ban Surprise Billing Act in this aspect.[242] Although the Consumer Protections Medical Bills Act protected beneficiaries seeking ordinary emergency and nonnetwork care in the same capacity as the No Surprises Act in terms of factor three,[243] the No Surprises Act nevertheless outdoes the Consumer Protections Medical Bills Act because it offers more protections against liability when it comes to air ambulance services, a provision absent from the Consumer Protections Medical Bills Act .[244]

Lastly, as illustrated above, the deciding factor in terms of comprehensive balance billing legislation is encapsulated in factor four: the dispute resolution method a federal balance billing proposal chooses to adopt.[245] In the case of the No Surprises Act, the No Surprises Act states that providers and insurers must resolve payment disputes using an IDR process similar to the dispute resolution provisions in both the Consumer Protections Medical Bills Act and the Ban Surprise Billing Act.[246] According to the No Surprises Act, if, after opening negotiations, a provider and insurer cannot come to an agreement regarding payment for services, either party may initiate a dispute resolution process in which an unbiased entity will determine the amount of payment based on a variety of factors.[247] As with the other proposals, according to the No Surprises Act, both the provider and insurer "shall each submit to the certified IDR entity . . . an offer for a payment amount," and the IDR entity must "select one of the offers submitted."[248] In this baseball-style arbitration the parties must accept the payment amount the arbiter chooses, making payment of that amount binding on the respective parties.[249] However, a possible con of the IDR process in the No Surprises Act is that there is no mini-

240. H.R. 133 § 2799B-1(a)(1).

241. *Id.* § 2799B-2(a).

242. H.R. 5800 § 2799A-1(a)(2).

243. Stauffer & Waldo, *supra* note 119.

244. *See generally* H.R. 5826; H.R. 133 § 9822(d)(1).

245. HOADLEY & LUCIA, *supra* note 52, at 10.

246. Press Release, House Comm. on Energy and Commerce, *supra* note 239; H.R. 5826 § 1150C(b)(1); H.R. 5800 § 4(a)(1).

247. H.R. 133 § 103(a)(c)(1)(B).

248. *Id.* § 103(a)(c)(5)(A)(i), (B)(i)(I).

249. Hoadley et al., *Unpacking the No Surprises Act*, *supra* note 121.

mum dollar amount to trigger the dispute resolution process.[250] As a result, as stated previously, the IDR process may not work as efficiently because allowing IDR for all payment disputes, without a minimum threshold, leads to more frequent arbitration and requires more resources than what may be available.[251] Nevertheless, having the IDR process in place satisfies the fourth factor that makes balance billing regulation comprehensive, and therefore, the No Surprises Act constitutes a comprehensive balance billing regulation that incorporates the four principal factors discussed throughout this Comment.[252]

Moreover, Congress ultimately made the correct decision in incorporating the No Surprises Act into the Consolidated Appropriations Act, 2021 rather than the Consumer Protections Medical Bills Act or the Ban Surprise Billing Act because the No Surprises Act also offers extensive protections for beneficiaries utilizing air ambulance services, an area that only federal law can regulate. For example, the No Surprises Act specifically states that "[t]he provisions of sections 2799B–1, 2799B–2, [and] 2799B–3 . . . shall apply to . . . an air ambulance provider[s]," and those are the provisions ridding beneficiaries of any liability in terms of surprise medical bills.[253] Therefore, the No Surprises Act is most effective in thoroughly protecting individuals who utilize air ambulance services. Unlike the Consumer Protections Medical Bills Act that failed to address air ambulance services, the No Surprises Act not only shields individuals from liability if they utilize air ambulance services, but it also goes a step further and prohibits providers from sending bills for such services.[254] Furthermore, although the Ban Surprise Billing Act essentially offered the same protections in terms of air ambulance use,[255] the fact that the No Surprises Act offers more complete protection to those seeking emergency care and offers greater clarity regarding self-insured plans indicates that Congress properly selected the No Surprises Act to be a part of the Consolidated Appropriations Act, 2021.[256] However, although the No Surprises Act took effect in January of 2022,[257] it is still necessary to explore the obstacles that this novel Act may experience once it is enacted.

250. H.R. 133 § 103(c).

251. Brannon & Kemp, *supra* note 3, at 43.

252. Hoadley, *supra* note 54, at 3–4.

253. H.R. 133 § 9822(d)(1).

254. *See id.* §§ 2799B-1(a)(1), 2799B-2(a).

255. H.R. 5800 § 2799A-4.

256. H.R. 133 §§ 102(b), 2799B-1(a)(1).

257. CTRS. FOR MEDICARE & MEDICAID SERVS., *supra* note 120.

IV. Impact

Even after its enactment, the No Surprises Act may still face several obstacles.[258] Private challenges under the Takings Clause, for example, may be capable of voiding federal balance billing regulation in the private sector.[259] Lobbying groups have the potential to denounce and destroy such federal balance billing regulations as well.[260]

A. Obstacles to Federal Balance Billing Regulations

Enacting comprehensive balance billing regulations at the state or federal level would mitigate the financial and emotional impact of receiving a surprise hospital bill.[261] Moreover, the impact of federal legislation like the No Surprises Act has an even further reach than state plans since these federal laws alone can protect the 2.4 million Americans insured by ERISA self-funded plans[262] and those who require air ambulance services.[263] Although the No Surprises Act has the ability to protect patients in areas that state laws cannot reach, the No Surprises Act may face unique challenges and complex litigation once enacted, forcing federal balance billing regulations back to square one.[264]

1. The Threat of the Takings Clause

The first major issue regarding federal balance billing regulations derives from the Takings Clause of the Fifth Amendment.[265] The Takings Clause states that "private property [shall not] be taken for public use, without just compensation."[266] Because nothing is physically being taken from providers with balance billing regulations, the federal government may only violate the Takings Clause if the federal balance billing regulations are so burdensome as to become a taking.[267] Courts then weigh the following three factors when determining whether the federal government's action amounts to a taking: (1) the economic

258. *See infra* Part IV.A.

259. *See infra* Part IV.A.i.

260. *See infra* Part IV.A.ii.

261. Erin C. Fuse Brown, *Consumer Financial Protection in Health Care*, 95 Wash. U.L. Rev. 127, 138 (2017); David A. Hyman et al., *Surprise Medical Bills: How to Protect Patients and Make Care More Affordable*, 108 Geo. L.L. 1655, 1674 (2020).

262. U.S. Dep't of Lab., *Fact Sheet: What is ERISA?*, https://www.dol.gov/agencies/ebsa/about-ebsa/our-activities/resource-center/fact-sheets/what-is-erisa (last visited May 2, 2022).

263. Hyman et al., *supra* note 261, at 1671.

264. Clement, *supra* note 21, at 7.

265. *Id.*

266. U.S. Const. amend. V, cl. 4.

267. Clement, *supra* note 21, at 7.

impact of the regulation on the claimant, (2) the extent to which the regulation has interfered with distinct investment-backed expectations, and (3) the character of the governmental action as an adjustment or an invasion.[268] Therefore, physicians will likely argue that the federal balance billing regulations implicate these factors in an attempt to keep balance billing intact so that they continue to receive a higher income.[269]

For instance, some providers and practice groups insist that the No Surprises Act fully implicates all three factors of the "takings" test since the No Surprises Act "threatens to both systematically devalue medical licenses and commandeer physical healthcare resources without providing just compensation."[270] On the other hand, those in support of federal balance billing legislation may argue, more powerfully and likely more successfully, that while prohibiting providers from balance billing may cause the providers to lose a portion of their income, providers will undoubtedly still receive sufficient payments from a patient's insurer.[271] Although the providers will not receive the out-of-network rates they hoped to obtain by remaining out-of-network, they will nonetheless receive in-network rates for the services they perform.[272] Furthermore, according to the notice and consent requirement of the No Surprises Act, these regulations do not affect patients who have consented to out-of-network care beforehand and who are willing to pay a balance bill in exchange for services from a specific provider.[273] As a result, the economic impact in terms of the first factor for determining a taking is likely not severe enough to constitute a taking.[274] Additionally, while providers have invested in their medical licenses,[275] just as with factor one, the impact of federal balance billing regulations on providers' ability to practice is not grave enough to implicate factor two either.[276] The No Surprises Act lacks any provisions indicating that it will strip doctors of their licenses or forbid them from engaging in a specific practice area.[277] Therefore, the federal balance billing regulations do not interfere with invest-

268. Penn Central Transp. Co. v. City of New York, 438 U.S. 104, 124 (1978).
269. CLEMENT, *supra* note 21, at 7.
270. *Id.*
271. CLEMENT, *supra* note 21, at 8.
272. *Id.*
273. H.R. 133, 116th Cong. § 2799A-1(b)(1)(A) (2020).
274. Christen Linke Young, *Federal Surprise Billing Legislation Does Not Violate the Constitution*, BROOKINGS (July 1, 2019), https://www.brookings.edu/blog/usc-brookings-schaeffer-on-health-policy/2019/07/01/federal-surprise-billing-legislation-does-not-violate-the-constitution/.
275. CLEMENT, *supra* note 21, at 9.
276. Young, *supra* note 274.
277. *See* H.R. 133.

ment-backed expectations to the point of invoking the Takings Clause.[278] The government's action also represents a "targeted adjustment" to protect consumers from the potential greedy nature of healthcare providers.[279] With the federal balance billing regulations, the federal government does not invade the providers' rights but instead, relieves patients of the surprise as well as the burden of paying unexpected costs for necessary care.[280] Consequently, although some providers may make a Takings Clause argument in an attempt to put a halt to the No Surprises Act,[281] this argument should fail, and the No Surprises Act should not face such Takings Clause issues when enacted. However, since there are arguments to be made on both sides, only time will tell if the No Surprises Act will face Takings Clause litigation and if the No Surprises Act will remain in effect, especially considering the impact that lobbying groups can have on federal balance billing legislation.

2. The Threat of Lobbying Groups

In addition to the Takings Clause, the federal government must also consider the power of lobbying groups to sway members of Congress when attempting to enact balance billing regulations. In 2019, the Senate Committee on Health, Education, Labor and Pensions and the House Energy and Commerce Committee reached a compromise regarding their respective balance billing proposals, incorporating the best aspects of each proposal into one bill.[282] Passage of the bill looked promising. However, December 2019 came, and the bill did not pass.[283] The bill failed because private equity-backed physician staffing companies and a lobbying group known as Doctor Patient Unity spent up to $28 million in ad campaigns to discourage House and Senate leaders from passing the bill, and their efforts worked.[284] Although Congress has already passed the No Surprises Act, the federal government must still remain vigilant and not underestimate the power of lobbying groups because such groups have already begun to question the legitimacy of rulemaking related to the No Surprises Act

278. Young, *supra* note 274.

279. *Id.*

280. CLEMENT, *supra* note 21, at 9.

281. *Id.* at 7.

282. Erin C. Fuse Brown, *Stalled Federal Efforts to End Surprise Billing-The Role of Private Equity*, 98 N.E. J. MED. 1189, 1190 (2020).

283. *See id.*

284. *Id.*; Hyman et al., *supra* note 261, at 1674 ("[A] vigorous ad campaign [was established] on the part of the affected specialties who would stand to lose money should such a law be enacted . . . .").

and have succeeded. For example, the members of the largest state medical society in the country, the Texas Medical Association, came together to file suit against the U.S. Department of Health & Human Services (HHS) to challenge rulemaking it issued in relation to the No Surprises Act in October 2021.[285] In February 2022, the U.S. District Court for the Eastern District of Texas sided with the Texas Medical Association and vacated the rules that HHS implemented regarding the IDR process found in the No Surprises Act.[286] The court held that the rules promulgated by HHS instruct the arbiters of the IDR process to rely too heavily on the qualified payment amount (QPA) as *the* factor when deciding payment disputes between providers and insurers when that was not the intent of the No Surprises Act.[287] The court definitively held that the "[r]ule places its thumb on the scale for the QPA."[288] Although this ruling only vacates certain rules that HHS set forth and does not impact the actual language of the No Surprises Act, this decision nevertheless reinforces the power that lobbying groups currently have and will likely continue to possess to challenge the No Surprises Act in the future.

IV. Conclusion

The unifying principle regarding balance billing regulations has been that "consumers should not be liable for surprise medical bills in circumstances where they have little or no control over whether their medical providers are in-network."[289] The No Surprises Act does just that. It fully protects beneficiaries regardless of the type of insurance they have, and in nearly all situations, it prohibits providers from sending balance bills in addition to holding the beneficiaries harmless.[290] Furthermore, it fills the crucial gaps in federal balance billing legislation that the Consumer Protections Medical Bills Act and the Ban Surprise Billing Act missed. Unlike the Consumer Protections Medical Bills Act, the No Surprises Act restricts balance billing from air ambulance providers, and unlike the Ban Surprise Billing Act, the

285. Tex. Med. Ass'n, *TMA Welcomes U.S. District Court Decision to Grant Its Summary Judgment Motion* (Feb. 23, 2022), https://www.texmed.org/Template.aspx?id=58782; Joey Berlin, *TMA Win on Surprise-Billing Rule Also a Win for Access to Care*, Tex. Med. Ass'n (Mar. 31, 2022), https://www.texmed.org/Template.aspx?id=58801.

286. Tex. Med. Ass'n v. U.S. Dept. Health & Hum. Servs., No. 6:21-cv-425-JDK, 2022 WL 542879, at *14 (E.D. Tex. Feb. 23, 2022).

287. *Id.* at *8; Berlin, *supra* note 285.

288. *Tex. Med. Ass'n*, 2022 WL 542879, at *8.

289. Hoadley, *supra* note 54, at 6.

290. H.R. 133, 116th Cong. § 102(b) (2020); Press Release, House Comm. on Energy and Commerce, *supra* note 239.

No Surprises Act more thoroughly protects beneficiaries seeking emergency care and those belonging to self-insured plans.[291] Despite the recent litigation in Texas, the No Surprises Act possesses a promising dispute resolution process to resolve payment issues as well.[292] In fact, if the dispute resolution process does not work as expected, Congress can still turn to a benchmark payment standard since it already has the framework for one from state legislation as well as the Ban Surprise Billing Act.[293] Therefore, by passing the No Surprises Act, hospitals will be able to more definitively act as neighbors within the community as well as maintain a positive reputation that will keep patients healthy and trusting of the medical providers that they seek out.[294] In doing so, providers will be properly compensated for their work, and patients will receive the treatment they deserve.

Georgie Bierwirth

291. *See supra* Part III.A-C.

292. H.R. 133 § 103(a)(c)(1)(B).

293. H.R. 5800, 116th Cong. (2020); Hoadley, *supra* note 54, at 5.

294. Stephen Walston, *A Policy Analysis of Balance Billing Legislation in Washington State*, UNIV. WASH. 16 (2020), https://digital.lib.washington.edu/researchworks/bitstream/handle/1773/46049/Walston_washington_0250O_21154.pdf).