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Summary of the No Surprises Act Enforcement Act

Overview:

The No Surprises Act, signed into law in late 2020, stands as one of the most substantial federal efforts to prevent the practice of surprise billing. Designed to prevent patients from receiving larger, out-of-network medical bills when unknowingly or unavoidably treated by unaffiliated providers, the law prohibits insurers and providers from balance billing for certain situations, such as out-of-network emergency services, out-of-network nonemergency services provided at in-network facilities, and out-of-network air ambulance services. These requirements typically apply to individual market plans, fully insured group plans, and self-insured plans. When plans or providers fail to negotiate a mutually agreed upon payment amount for services eligible for No Surprises Act Protections, they typically enter into an Independent Dispute Resolution (IDR) process, in which the insurer and out-of-network provider each submit payment offers to a neutral, third-party arbitrator. The third-party entity then makes a binding determination of reasonable payment, to which the applicable insurer or provider is required to pay out.

Following implementation of the No Surprises Act in 2022, insurers, providers, and employers have flagged a number of issues with the law's requirements. Many insurers have pointed to the IDR process as overtly biased towards provider offers. Research from the Congressional Budget Office found that 3.4 million No Surprises Act disputes were filed between 2022 and mid-2025, primarily by providers, with over 80% of IDR determinations favoring the provider offer in that time period. Provider groups have pointed to the frequency of favorable IDR rulings as evidence of consistent insurer underpayment, with some arguing that disputes are often un- or underpaid by insurers. Provider critics of No Surprises Act implementation also point to qualifying payment amounts (QPAs)—which are average in-network rates for services in a geographic area and are used in determining the final IDR offer—as tools to artificially deflate insurer payouts. Insurers have argued that the IDR process has allowed for payment awards that substantially outpace QPAs. CMS has stated that in the last six months of 2025, the IDR offer exceeded the QPA in roughly 87% of payment decisions. On Aug. 11, a federal appeals court for the 5th Circuit ruled that the federal government's formula for calculating QPAs was unlawful.

Ahead of the 2026 midterm elections, Congress may take action to tackle these No Surprises Act challenges with a package of legislative fixes. On July 23, Representative Greg Murphy (R-NC) and Senator Roger Marshall (R-KS) introduced companion versions of the **No Surprises Act Enforcement Act** (H.R. 4710/S. 2420). The bill is geared specifically toward increasing penalties for insurers who violate the No Surprises Act and is gaining traction in the House of Representatives with 36 bipartisan cosponsors as of Aug. 20. According to Punchbowl News, the House Ways and Means Committee is in the process of developing a package that includes the No Surprises Act Enforcement Act, as well as provisions designed to reduce the frequency of ineligible provider claims. The committee may hold a

markup of the bill as early as September. However, legislators must contend with unrelated legislative hurdles, including the expiration of federal government funding on Sept. 30, the midterm election on Nov. 3, and the end of the congressional term on Dec. 31. Regardless of the outcome of No Surprises Act reform during the 119th Congress, legislators are likely to target health insurer practices for the foreseeable future. And while text of the potential Ways and Means package remains unavailable, AMCP has compiled a summary of the insurer penalty provisions in the No Surises Act Enforcement Act, included below.

Bill Summary:

The No Surprises Act Enforcement Act would amend the existing federal group insurance enforcement authority under the Public Health Service Act—as well as the employer based insurance enforcement frameworks under the Employee Retirement and Income Security Act (ERISA) and Internal Revenue Code (IRC)—to allow for substantially steeper penalties of $10,000 for each instance in which an insurer violates the No Surprises Act. Such violations include impositions of prior authorization requirements on in- and out-of-network emergency services; improper cost-sharing requirements, such as higher deductibles or copays, for out-of-network emergency services performed at in-network facilities; improper cost-sharing requirements for non-emergency services performed by nonparticipating providers at participating facilities; and improper cost sharing for out-of-network air ambulance services. Current law imposes a federal penalty on *providers* of up to $10,000 per violation of the No Surprises Act, while insurers face penalties of up to $162 per day (group and individual issuers) or $100 per day (employer-sponsored group plans) for each violation during a noncompliance period.

The bill would also impose additional penalties for late or non-payment by providers, as well as private individual and group insurers after the statutorily required IDR process is completed. For instances in which the IDR determination amount for emergency and nonemergency services is less than initial payment plus any related cost-sharing amounts, the nonparticipating provider or facility would be required to pay the difference to the plan within 30 days of a determination being made. Plans, nonparticipating providers, or nonparticipating facilities that are required to make a payment following a determination must submit a notification of such payment to HHS. Plans, nonparticipating providers, or nonparticipating facilities that fail to make the required payment following an IDR determination would be mandated to pay an amount three times the difference between:

- The initial payment (or $0 in the case of a notice of denial of payment); and
- The out-of-network rate for the item or service.

Such penalty amounts would be in addition to the initial payment, plus interest. The PHSA, ERISA, and IRC would also be amended to also apply this provision to air ambulance services.

The bill would also impose additional transparency and reporting requirements for HHS following enactment of the bill. HHS would be required to submit an initial report to Congress, for years beginning in 2022 and ending on Dec. 31 of the year of enactment, on the number of plans that were audited by the federal government under authorities granted by the No Surprises Act. Beginning on Feb. 1 of the first year after the bill is enacted and every six months thereafter, HHS, the Department of Labor, and the Department of the Treasury would be required to submit joint reports to the House and Senate committees with primary jurisdiction over health policy. Such reports must include details on audits conducted; provider and beneficiary complaints submitted; enforcement and corrective

actions taken; total civil monetary penalties issued; and a description of the three most commonly reported violations in each six-month period.