CHA SUMMARY OF KEY PROVISIONS – FEBRUARY 2021

The No Surprises Act

Overview

The No Surprises Act limits patient out-of-pocket costs to the in-network amount for emergency medical care provided by out-of-network facilities and providers. It also limits patient out-of-pocket costs to the in-network amount in certain situations where care is delivered at an in-network facility by an out-of-network provider. The legislation establishes an independent dispute resolution (IDR) process to determine the amount plans will pay non-contracted facilities and providers in covered situations. It also places requirements on plans, facilities, and providers to provide patients with an advanced explanation of benefits (EOB) for scheduled services. Below is a section-by-section summary of the legislation's key provisions.

Section 101 – Short title

No Surprises Act

Section 102 – Health insurance requirements regarding surprise medical billing

Health plans are required to cover emergency services delivered by out-of-network facilities and providers without prior authorization. Coverage must be provided as if the emergency services were provided in-network, at the in-network cost-sharing amount. For this provision, "emergency services" are defined to include post-stabilization services unless certain conditions are met. These conditions include:

- The patient can travel using nonmedical or nonemergency medical transportation.
- The provider satisfies the notice and consent requirements established in the legislation (see Section 104 below).
- The individual can receive notification and providing informed consent.
- Other conditions as specified in rulemaking

Health plans must either pay the claim or issue a notice of payment denial to the provider within 30 calendar days after receiving the claim in question. The plan must pay providers directly (instead of paying the patient). Cost-sharing related to the out-of-network emergency service counts toward the patient's deductible/out-of-pocket cost-sharing maximum as if the services were provided in-network using one of the amounts discussed below.

The patient's in-network cost-sharing amount is calculated using the "recognized amount" and "qualifying amount" (described below). The recognized amount is one of the following based on the applicable scenarios:

1. *States with surprise billing legislation*: Amount required under state law that applies to the patient situation and service
2. *All-payer rate setting*: Amount determined by the state's all-payer rate setting model
3. *Qualifying amount*: Amount used to determine the recognized amount if scenarios 1 and 2 do not apply. In addition to applying in states without surprise billing legislation, this amount will likely apply to non-state regulated products (e.g., ERISA plans) in states that have surprise billing legislation.

If the patient's coinsurance is a percentage of the allowable amount (e.g., 15%) for in-network emergency services, for emergency services delivered by an out-of-network provider, the patient's coinsurance is 15% of the "recognized amount."

The qualifying amount is based on the median contracted rate recognized by the health plan on January 31, 2019, within the same insurance market[1]. This amount is trended forward to the year in question using the urban consumer price index. If a plan did not offer coverage in 2019 or does not have sufficient information to calculate the qualifying amount, the legislation requires the use of the median contracted rate from the first available plan year or information from an independent database (e.g., all-payer claims database).

Regulations establishing the qualified amount are required by July 1, 2021. The legislation requires that the qualifying amount be based on a number of factors, including: the applicable insurance market (e.g., individual, small group, or large group), the geographic area (including whether services were delivered in a rural area or underserved area), and provider characteristics that may impact payment amounts (e.g., facility case mix).

Out-of-network providers will be paid an "out-of-network rate" for services covered by the legislation. The actual "out-of-network rate" will depend on the state and services provided:

1) *States with surprise billing legislation*: For services subject to state surprise billing laws that establish the payment amount or process to determine the payment amount in out-of-network situations, the "out-of-network rate" is determined based on state law.
2) *Rate setting states*: In states that use all-payer rate setting, the "out-of-network rate" is the all-payer rate for the item or service.
3) *Negotiated/arbitrated rate*: If neither of the two scenarios above apply, the "out-of-network rate" is either the amount agreed to by the plan and provider or the rate determined through the IDR process.

The legislation also protects patients against surprise bills — in certain circumstances — when a patient receives services from an out-of-network provider at an in-network facility. Unless the provider has offered notice and received the patient's consent to receive out-of-network services, cost-sharing in these circumstances is limited to the in-network amount, and the process to determine the provider's payment is the same as described above for emergency services. As discussed in Section 104 below, certain services are excluded from the notice and consent process.

[1] For example, the individual market median contracted rate cannot be used to establish the qualifying amount for an ERISA plan.

Section 103 – Determination of "out-of-network rates" to be paid by health plans; IDR process

Where state-specific surprise billing laws exist, the legislation defers to them for state-regulated products. If there is no state law (or for products not covered by state law), effective on January 1, 2022, unless otherwise noted, the legislation creates a three-step process for determining payment to providers for covered out-of-network situations:

1) *Accept initial payment*: The provider may accept the initial payment amount made by the plan.
2) *Negotiate acceptable amount*: The health plan and provider may negotiate an agreeable amount during the 30-day period that begins on the day the provider receives the initial payment or denial from the health plan.
3) *IDR process*: If steps one and two fail, the health plan or provider may settle an outstanding dispute using the IDR process. The losing party in the IDR process incurs the cost of the arbitration. During this process, the parties may continue negotiating and do not need to complete the IDR process if they are able to arrive at an acceptable amount on their own. In this case, the parties split the cost of arbitration. The Departments of Health and Human Services (HHS), Treasury, and Labor (hereafter, tri-agencies) must jointly issue regulations establishing the IDR process by December 27, 2021.

In the event the health plan and provider cannot come to an agreement on an acceptable payment amount for out-of-network situations covered by the legislation, either party may initiate the IDR process within four days of the end of the 30-day negotiating period (referred to as notifying). The parties have three days to jointly select an IDR entity to oversee the arbitration. If they cannot come to an agreement or do not select and IDR entity, the HHS Secretary has three days to jointly select one on their behalf.

Once an IDR entity is selected, the parties have 10 days to submit an offer for reimbursement, along with any supporting materials. The legislation requires the IDR entity to select one of the party's offers, without modification, within 30 days of the selection of the IDR entity. Once the IDR entity has ruled, the health plan must remit payment to the provider within 30 days, if appropriate.

The party that initiated the IDR process may not submit another case for the same item or service involving the same counterparty during the 90-day period ("cooling off period") following a decision. However, the party may hold claims and submit them to the IDR after the "cooling off period" ends.

Cases may only be batched and submitted to the IDR process if they involve the same provider or facility, the same insurer, treatment of the same or similar medical condition, and occur within a single 30-day period. The forthcoming regulations will provide additional detail for batching and may adjust the timeframe.

Arbiters may consider the following factors as submitted by the parties when arriving at a decision:

- Qualifying payment amount for the item or service
- Provider's level of training or experience
- Quality and outcomes of the provider
- Plan/provider market share
- Patient acuity
- Teaching status

- Case mix
- Provider's scope of services
- Good faith efforts to enter into a network agreement with the other party
- Contracted rates between the parties during the previous four years (if applicable)

IDR entities may not consider billed charges or rates paid by public programs (e.g., Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE).

The legislation details eligibility criteria for IDR entities and directs the tri-agencies to establish a certification process through regulation. IDR entities must have legal and medical expertise and sufficient staff necessary to make decisions within the timeframe required by law. Potential IDR entities may not be a health plan, provider, or association of either plans or providers. IDR entities must also meet fiscal integrity, confidentiality, and other requirements. Entities will be certified for five years.

Section 104 – Health care provider requirements regarding surprise medical billing

Effective January 1, 2022, out-of-network health care facilities and providers may not balance bill for emergency services provided out of network. The legislation also prohibits balance billing for services delivered at an in-network facility by an out-of-network provider unless the notice and consent process requirements and certain conditions are met.

Providers must notify the patient and obtain consent in writing 72 hours before scheduled, out-of-network services are to be delivered to insured patients or if the service is scheduled within that timeframe, when the appointment is made. The legislation creates a separate notice and consent process (discussed below) for uninsured patients.

Based on the patient's preference, notice and consent can be provided in paper or electronic form. The notice must be available in the 15 most common languages spoken in the provider's area and must contain the following:

- Good faith estimate (GFE) of the charges
- List of in-network providers at the facility (if the facility is in-network) to which the patient can be referred
- Information on any prior authorization or other care management requirements
- A statement that consent is optional, and the patient can instead opt for an in-network provider.

The legislation requires the use of a form that includes space to obtain the patient's signature, a cost estimate, and the date the notice was provided, and consent obtained. The HHS Secretary is instructed to issue further guidance on the form's requirements by July 1, 2021.

The notice and consent process may not be used for an out-of-network provider in instances where there is no in-network provider available at the facility to provide the item or service in question. Additionally, it does not apply to emergency services, items or services resulting from an unexpected medical need occurring during a procedure or service for which consent was obtained, and certain ancillary items. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services. The HHS Secretary, through rulemaking, may add additional items to this list or remove certain advanced diagnostic tests.

The legislation identifies states as the primary enforcement agent. If states fail to act against violators, the HHS Secretary may issue civil monetary penalties of up to $10,000 per violation. The penalties may be waived if the provider unknowingly commits a violation, withdraws the bill, and reimburses the patient (or plan) for any amounts received including interest. The Secretaries of HHS and Labor are required to create a process to receive consumer complaints by January 1, 2022.

Section 105 – Ending surprise air ambulance bills

Beginning on January 1, 2022, air ambulance providers are prohibited from billing out-of-network patients more than the in-network cost-sharing amount. Similar to the process for facilities and providers, health plans and air ambulance providers have a 30-day period to negotiate an agreeable payment amount for services where the initial amount is in dispute or the initial claim is denied. If the negotiation fails to reach an agreement, either party could trigger the IDR process using the same process outlined for facilities and providers. The tri-agencies are required to issue regulations by December 27, 2021.

Section 106 – Air ambulance reporting requirements

The legislation requires air ambulance providers to report cost and claims data to Departments of HHS and Transportation. The agencies are required to issue regulations implementing reporting requirements by December 27, 2021. The requirements would commence within 90 days of the final rule.

Section 107 – Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations

For plan years beginning on or after January 1, 2022, group and individual health plans must include the following information on insurance cards:

- Any applicable deductible, including in and out of network amounts
- Out-of-pocket maximum limits, including for in and out-of-network limits
- Phone number and website for consumer assistance

Section 108 – Implementing protections against provider discrimination

The tri-agencies are instructed to issue rules by January 1, 2022, implementing Affordable Care Act changes to the Public Health Service Act protections against provider discrimination. These protections are currently implemented by sub-regulatory guidance.

Section 109 – Reports

The legislation instructs various federal agencies to issue reports on the implications of the No Surprises Act on health plan and provider consolidation, provider network adequacy, consumer out-of-pocket costs, and the IDR process.

Section 110 – Consumer protections through application of health plan external review in cases of certain surprise medical bills

In situations where a health plan determines the surprise medical billing protections included in the No Surprises Act do not apply, the tri-agencies are required, by January 1, 2022, to establish an external review process to ascertain if the plan's determination was correct.

Section 111 – Consumer protections through health plan requirement for fair and honest advance cost estimate

Effective for plan years beginning on or after January 1, 2022, health plans are required to send patients an "Advanced Explanation of Benefits" (AEOB) prior to scheduled care or upon request from a patient prior to scheduling.

If the service is scheduled at least 10 business days in advance, health plans must provide this information within three business days of receiving a request or scheduling notice. If the service is scheduled in less than 10 business days, the notice must be provided within one business day of receiving the request. Patients may elect to receive this information by mail or electronically.

The requirement is initiated when a provider sends a "good faith estimate" (GFE) to the plan as required in Section 112 of the legislation (discussed below). A patient may also request an AEOB from their health plan. An AEOB includes these eight components:

1) Network status of the provider or facility providing the item or service
    a. For in-network providers/facilities, the contracted rate for the item or service, based on the billing and diagnostic codes sent by the provider must be included.
    b. For out-of-network providers/facilities the health plan must include information on how to locate an in-network provider.
2) A GFE of anticipated charges based on the billing/diagnostic codes sent by the provider/facility
3) An estimate of the amount the plan will cover for the items and services identified in the GFE
4) An estimate of the patient's out-of-pocket costs
5) An estimate of the amount the beneficiary has accrued toward cost-sharing limits
6) Any disclaimers indicating the applicability of any medical management or review (e.g., prior auth, step therapy) requirements for the items or services
7) A disclaimer indicating the estimate is based on information available when the service was scheduled
8) Other disclaimers the health plan deems appropriate

Section 112 – Patient protections through transparency and patient-provider dispute resolution

Effective January 1, 2022, facilities and individual providers are required to provide a patient's health plan (if the patient is insured) or the patient (if uninsured) GFEs that include the estimated total charges – including those for ancillaries – for scheduled items or services. The notice must include the anticipated diagnostic/billing codes for the scheduled items and services to be provided.

Facilities and providers must provide the GFE at least three business days before the service is furnished and no later than one business day after scheduling. If the service is scheduled for more than 10 business days later, the provider will need to furnish the information within three business days of the patient requesting an estimate or scheduling a service.

The HHS Secretary is also instructed to establish a patient-provider dispute resolution process. The process is intended to resolve pricing disputes arising from GFEs for uninsured patients that are substantially higher than the bill received by the patient. This will function as an IDR process for uninsured patients.

Section 113 – Ensuring continuity of care

When a health plan terminates coverage, or a facility/provider drops out of a health plan's network, patients undergoing continuous care may continue to receive services from the now out-of-network provider for up to 90 days under the terms and conditions that were applicable prior to contract termination to allow for a transition of care to an in-network provider.

The legislation defines continuing care patients as those who are undergoing treatment for a serious or complex condition, undergoing institutional or inpatient care, scheduled to undergo non-elective surgery including post-operative care, pregnant and undergoing treatment, or terminally ill and receiving services.

Section 114 – Maintenance of price comparison tool

For plan years beginning on or after January 1, 2022, health plans must make price comparison guidance available by phone and on the internet. The tool will allow enrollees to compare the expected out-of-pocket costs for items and services across multiple providers.

Section 115 – State all payer claims databases

The HHS Secretary is instructed to make one-time grants to states for the purpose of establishing or improving all payer claims databases. The Secretary is instructed to develop an application process that includes how states will ensure uniform data collection. The HHS Secretary is also instructed to create a voluntary reporting standard for ERISA plans.

Section 116 – Protecting patients and improving the accuracy of provider directory information

Health plans are required to create a verification process to ensure the accuracy of their provider directories. The legislation requires plans to verify and update provider directory information no less than every 90 days (or within two days of receiving a change notice). Health plans must also develop a process for removing providers and facilities that no longer participate in the network. The requirement is effective for plan years beginning on or after January 1, 2022, and does not pre-empt state law.

Patients who relied on out-of-date network information and received services from an out-of-network provider are responsible only for the in-network cost sharing amount.

Section 117 – Advisory committee on ground ambulance and patient billing

The legislation instructs the secretaries of the tri-agencies to create an advisory committee on ground ambulance patient billing. The advisory committee is tasked with examining options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for services, and protect consumers from balance billing.

Section 118 – Implementation funding

Congress is appropriating $500 million to implement the No Surprises Act.

Contact

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