“No Surprises Act” – Protections Against Surprise Billing for Out-of-Network Care

CHA Summary of Key Provisions

On Dec. 27, 2020, the president signed H.R. 133, which combines a COVID-19 relief package, FY 2021 omnibus appropriations and the “No Surprises Act” to address surprise billing with other pieces of legislation. The “No Surprises Act” protects patients from surprise bills and uses an arbitration approach—rather than a benchmark payment standard—to settle payment disputes between payers and providers in cases of out-of-network care, a significant improvement from prior proposals that addresses a number of concerns that children’s hospitals and other providers had expressed.

Key elements of the “No Surprises Act” include:

- A prohibition on balance billing in emergency situations or when care is provided by an out-of-network provider at an-network facility, unless the patient has been notified that the provider is out-of-network and they have consented to that out-of-network care.
- The ability of plans and providers to reach a negotiated agreement on payment in instances of out-of-network care with an arbitration process as a backstop if those negotiations fail. The arbitration process requires the arbiter to choose between the payer's and provider’s payment offers taking into consideration the median contracted rate for similar services and providers in the geographic area and other factors such as facility type, prior payment history, patient acuity, case mix, quality measurements and provider training.
- A requirement that providers confirm a patient’s network status and provide them with a “good faith estimate” (in clear and understandable language) of the expected charges for scheduled items and services.

The Act does not include timely billing requirements and specifically excludes public payers (Medicare, Medicaid, CHIP and TRICARE) from the determination of the median payment rate for the arbitration process.

Detailed Summary

Entities subject to legislative requirements

The provisions of the “No Surprises Act” apply to the following entities and programs

- Providers
  - Out-of-network emergency services and ancillary providers at in-network facilities, including independent freestanding emergency departments (geographically separate and licensed separately from a hospital) and the emergency department of a hospital
  - Physicians and other health care providers acting within the scope of practice of that provider’s license or certification under applicable state law
  - Air ambulances
- Group health plans (fully-insured and self-funded) and individual health plans
- The Federal Employee Health Benefit Plan
Out-of-pocket protections for patients receiving out-of-network care

Beginning, Jan. 1, 2022, out-of-network facilities and providers are prohibited from sending patients surprise bills for more than the in-network cost-sharing amount for out-of-network emergency care or for out-of-network care provided at in-network facilities.

- Patients are only required to pay the in-network cost-sharing (i.e., co-payment, coinsurance and deductibles) amount unless the patient receives notice that care will be out-of-network at least 72 hours prior to an elective procedure. In the case of appointments made within 72 hours of that appointment, the patient must receive the notice at the time of scheduling and consent to receive out-of-network care.
  - Under these circumstances, patients’ in-network cost-sharing payments for out-of-network surprise bills are attributed to a patient’s in-network deductible.
- If no notice and consent is provided, the patient cannot be balance billed in out-of-network situations.
- Patient notices must include:
  - An oral and written explanation (available in the 15 most common languages in that region) that states that the patient may seek care by an in-network provider.
  - The good faith estimated amount the provider may charge the patient, including a statement that the estimate and consent to be treated is not a contract in terms of the estimate.
  - In the case of an in-network facility and an out-of-network practitioner, a list of any in-network practitioners at the facility who can provide the services.
  - Information about any prior authorization or utilization review requirements.
- Patient consent forms for out-of-network care must acknowledge receipt of the notice and the expected out-of-pocket costs.
- Providers must retain signed notices for seven years after date of service.

Determination of qualifying payment amount (median payment rate)

By July 1, 2021, the Secretaries of HHS, Labor and Treasury (Secretaries) must issue regulations that establishes the health plan methodology for the determination of qualifying payment amounts for an item or service, which will be used in any arbitration to settle plan-provider payment disputes. The methodology must:

- Take into account geographic regions, payments that are not fee-for-service and relevant payment adjustments for quality or facility type (including higher acuity settings and case-mix of various facility types) that are otherwise taken into account to determine in-network rates.
- For services provided in 2022, use the median of contracted rates (total maximum payment, including cost-sharing and the amount paid by the plan) on Jan. 31, 2019, for all plans under that insurer that are offered in the same market for all similar types of items and services by providers in the same or similar specialty in the geographic region, increased by the CPI-U percentage for 2019 and then again for 2020 and 2021. For service provided between 2023 and subsequent years, use the median contracted rate for the prior year, increased by CPI-U.
  - The Secretaries must consult with the National Association of Insurance Commissioners to identify the geographic regions that will be applied to the determination of the qualifying payment amount.
- Allow for the determination of a qualifying payment amount for plans that did not offer coverage in that geographic region in 2019, which is increased by CPI-U for each year.
- Provide for a substitute methodology when the median contracted rate cannot be calculated using the above methodology due to insufficient information. Plans must use an independent, unbiased database (such as a state all-payer claims database) for information on allowed amounts paid for relevant services in the geographic region, increased by CPI-U for each year.
- Specify what information insurers must share with out-of-network providers regarding the determination of that qualifying payment amount.

By October 2021, the Secretaries must also issue regulations delineating a methodology for the audit of health plans’ compliance with the rules for the determination of their median contracted rates.
Payer-provider payment negotiations and arbitration process
The act establishes a 30-day plan-provider negotiation period to settle out-of-network claims for out-of-network emergency care or for out-of-network care provided at in-network facilities prior to any arbitration action, beginning the day the provider receives an initial payment or payment denial from the plan.

- Initiation of an independent dispute resolution arbitration process (IDR)
  - The plan or provider may request an IDR arbitration of the claim dispute within four days of the end of the 30-day negotiation period by sending an IDR notice to the other party and the Secretaries.
  - Providers may batch similar services in one proceeding when claims are from the same payer and the services were provided during the same 30-day period.
  - The payer and provider may continue negotiations after the IDR is initiated, but will be responsible for compensating the IDR arbiter regardless of the outcome of those negotiations.

- Selection and certification of IDR arbiter
  - The Secretaries will establish a process for the selection and certification of a sufficient number of arbiter to ensure timely and efficient payment determinations. Arbiter will be certified for five-year terms.
  - The entities must be independent, with no affiliation to providers or payers, and have sufficient medical, legal and other expertise, and sufficient staffing to make determinations on a timely basis.

- Arbitration process
  - Within three days of initiating an IDR arbitration process, the provider and plan must jointly select a certified arbiter. If they are unable to come to agreement, the Secretaries will select the arbiter.
  - The arbiter must make a payment determination within 30 days of being selected.
  - The payer and provider will each present their best and final offers, with supporting information, to the arbiter. Supporting information may include any information requested by the arbiter, as well as information that the plan or provider deem relevant.

- Arbiter’s considerations when choosing the final payment amount must include:
  - The market-based median in-network rate for the applicable year for comparable items or services that are furnished in the same geographic region.¹
  - Relevant information brought by either party.
  - Other factors, which may include the provider’s training and experience, patient acuity, the complexity of furnishing the item or service, provider quality and outcomes measurements, case mix, scope of services, the facility’s teaching status, demonstrations of (or lack of) good faith efforts to enter into a network agreement, prior contracted rates during the previous four plan years, provider’s market share in that geographic area and other items.
  - The arbiter is prohibited from considering billed charges and public payer (e.g., Medicaid, CHIP, Medicare or TRICARE) rates.

- The plan must pay the provider the determined payment amount within 30 days of that determination.
- The party that initiated the IDR may not take the same party to another IDR proceeding for the same item or service for 90 days following a determination by the arbiter.
  - Claims that occur during that 90-day “cooling off” period may still be eligible for IDR after the 90 days.
- IDR fees – the party whose offer is not chosen is responsible for paying all arbitration fees. In the event that the payer and plan agree to a payment rate on their own after the IDR process has been initiated, each party must pay one-half of the fees.
  - The amount of the fees will be determined by the Secretaries each year so that they cover the total annual costs of carrying out IDR determinations.

Surprise air ambulance bills
The act applies similar protections to patients against surprise air ambulance medical bills and establishes an IDR process following a 30-day period of payer-provider negotiation to settle out-of-network claims.

¹ As determined by the health plan based upon rulemaking on the calculation methodology for the qualifying payment amount.
• Requires air ambulance providers to submit two years of cost data to the Secretaries of HHS and Transportation, and insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS.

Consumer notification requirements/good faith estimates
The act includes several requirements for plans and providers to give patients estimates of their potential out-of-pocket costs, beginning Jan. 1, 2022.

• Insurer responsibilities
  o Health plans must include the enrollee’s in-network and out-of-network deductibles and out-of-pocket maximums on their insurance cards. They must also maintain online price comparison tools that allow patients to compare expected out-of-pocket costs for items and services across multiple providers.
  o Plans must send patients an “Advanced Explanations of Benefits” (AEOB) prior to scheduled care or upon request by patients looking for more information prior to scheduling. The AEOB must include:
    ▪ The provider’s network status and the contracted rate for the item or service (if in-network) or information on finding in-network providers for the item or service (if out-of-network).
    ▪ A “good faith estimate” (from the provider) of charges with a delineation by the health plan of the portion the patient should expect to pay and the portion the plan is expected to pay, as well as an estimate of the amount the patient has incurred toward their deductible and cost-sharing limits.
    ▪ Information on any utilization review required for the item or service.
    ▪ A disclaimer that all information included in the AEOB is an estimate and subject to change.
    ▪ A list of all in-network providers able to furnish the item or service.

• Provider responsibilities
  o All providers must confirm a patient’s network status and provide them with a “good faith estimate” (in clear and understandable language) of the expected charges for scheduled items and services.
    ▪ The notice must be provided no later than one day following the scheduling of an appointment for services that will take place at least three days later; in the case of services that are scheduled 10 or more days in advance, notice must be provided within 72 hours of scheduling; and in the case of services that will be provided within three days of scheduling, notice must be provided at the time of scheduling. The patient must sign the notice.
    ▪ The good faith estimate must be for the expected charges, including any item or service that could be reasonably expected to be provided in conjunction with those items or services, as well as those that could be expected to be provided by another health care provider.
    ▪ The estimate must include the expected billing and diagnostic codes.
  o The HHS Secretary must establish a “patient-provider dispute resolution process” to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the good faith estimate.

Continuity of care
Beginning Jan. 1, 2022, patients undergoing medical care for a serious or complex condition, undergoing inpatient service, or scheduled to undergo nonelective surgery are eligible for continued coverage with in-network cost-sharing if their provider leaves the network.

• The continuous coverage will end on the earlier of 90 days or the date when the patient is no longer under the care of the provider.

Provider directory accuracy
Beginning Jan. 1, 2022, plans must verify and update their provider directories at least once every 90 days.

• Plans must establish provider verification procedures and processes for the removal of providers from the directory when they have been unable to verify the provider’s status during a period specified by the plan.
• Plans must establish procedures to update their directories within two business days of the receipt of provider notice of a status change.
• Plans must respond to patient inquiries regarding a provider’s network status within one business day.
• Patients are protected from out-of-network cost-sharing if they receive care from an out-of-network provider due to directory errors.

Reports
The act includes a number of mandated reports.

• IDR process – On a quarterly basis, beginning in 2022, the Secretaries must post on their websites the number of IDR requests; the identity, type and practice size of the provider and identity of the insurer involved in the disputed payment; a description and the geographic location of the items and services under dispute; the amounts offered by the plan and provider during the IDR process, expressed as a percentage of the qualifying payment; whether the final selected payment was the offer by the plan or provider and its amount, expressed as a percentage of the qualifying payment; the number of times the final agreed-upon amounts exceed the qualifying payment amount, specified by items and services; the amount of time needed to come to a payment determination through the arbitration process; related expenditures to conduct IDR proceedings; and total fees paid to arbiters.

• 90-day “cool down” period – The Secretaries must submit a report to Congress within two years of enactment on the impact of the 90-day prohibition on subsequent IDR claims following a determination for the same service by the same provider and plan. The report must examine whether any plans have a pattern of denials, low payments or down-coding of claims during the 90-day period and include recommendations to discourage those types of practices.

• Audit of health plans on median rates – Beginning in 2022, the Secretaries must provide annual reports to Congress on the number of health plans that were audited to determine their compliance with requirements related to the calculation of their median contracted rates.

• Impact of legislation on health care consolidation, costs and access – The Secretaries, in consultation with the Federal Trade Commission and Attorney General, must submit an annual report to Congress on the effects of the legislation, beginning in 2023 and for each of the following four years. The report must examine patterns of vertical or horizontal integration of health care facilities, providers, or health plans; overall health care costs; and access to health care items and services, including specialty services in rural areas and health professional shortage areas. The report must include recommendations on ways to address potential anti-competitive consolidation of health care providers or health plans.

• Impact of surprise billing laws on network adequacy and out-of-pocket costs – By Jan. 1, 2025, the GAO must report on the impact of the legislation and state surprise billing laws on network adequacy, out-of-pocket costs and access to providers, including providers in rural, medically underserved communities and health professional shortage areas.

• Network adequacy – By Jan. 1, 2023, the GAO must report to Congress on health plan network adequacy with recommendations on ways to improve network adequacy.

• Impact of IDR on relationship between private equity firms and providers – By Dec. 31, 2023, the GAO must provide Congress with an analysis of potential financial relationships between providers that use the IDR process and private equity investment firms.

• Prescription drug pricing trends – HHS must publish on its website a report on prescription drug pricing trends and their impact on health insurance premiums 18 months after the date of enactment, and every two years thereafter.

State All-payer Claims Databases (APCDs)
The legislation establishes a grant program to fund the establishment and maintenance of state APCDs and requires grantees to make data available to all authorized users, including insurers and providers.

• The Department of Labor must create a national standard claims format for APCDs, which states must use if they require self-funded plans to participate in their APCD.

• Provides $50 million in grants in FYs 2022 and 2023, and $25 million in FY 2024 or until spent.
Other provisions

- **Ban on gag clauses on price and quality information** – Beginning one year after enactment, the act bans gag clauses in payer-provider that prevent enrollees, plans or referring providers from seeing cost and quality data on providers, or prevent plans from accessing de-identified claims data that could be shared with third parties for plan administration and quality improvement purposes.

- **Strengthening parity in mental health and substance use disorder benefits** – No later than 18 months following enactment, the Secretaries must finalize mental health parity guidance or regulations that specifies how insurers must comply with the act’s requirement that they conduct comparative analyses of nonquantitative treatment limits (e.g., prior authorization requirements) that are used for medical and surgical benefits compared to mental health and substance use disorder benefits.
  - The Secretaries must request comparative analyses from at least 20 plans per year to identify instances of noncompliance and release an annual report with a summary of comparative analyses findings, beginning one year after enactment.

- **Reporting requirements for plans on pharmacy benefits and drug costs** – Beginning one year after enactment, plans must report on plan medical costs and prescription drug spending to the Secretaries.