No Surprises Act Summary

- **ER Related Requirements**
  - All plans/issuers which cover emergency room services must cover all emergency services:
    - without need for prior authorization,
    - whether the provider is associated with a hospital or freestanding,
    - whether the provider is in-or out-of-network,
    - if by an out-of-network provider:
      - without the imposition of more stringent requirements or limitations than in-network providers;
      - at the same cost-sharing levels as in-network providers that would result if the amount charged for such services were equal to the **recognized amount.**
  - The plan or issuer must respond to a bill from a non-participating provider within 30 days of receipt with either an initial payment or a notice of denial of payment, where:
    - The insurer pays the amount by which the out-of-network rate exceeds the cost-sharing amount paid by the member, and
    - The member's cost sharing amount counts towards any in-network deductible/OOP maximums
  - Audit Process
    - By 10/1/21, the Secretaries (when I refer to them in the plural that means DHHS, DoL and the Treasury) will generate a process through rulemaking to ensure that all plans will be in compliance with the requirements hereunder related to the **qualifying payment amount**.
    - Each year beginning in 2022, the Secretary will audit up to 25 group health plans/issuers for proper calculation of the **qualifying payment amount**, using historical claims.
      - This number may grow to the extent that there are complaints investigated
    - The Secretary will produce a report for Congress each year with respect to the number of entities audited
  - **Emergency Medical Condition** is defined as any issue which threatens life, impairment of bodily function, or dysfunction of any bodily organ, in the opinion of a prudent layperson.
  - **Emergency Services** are defined as the care received necessary to screen and stabilize a patient. Additional services may be included to the extent that they are furnished after stabilization as part of outpatient observation or an inpatient stay related to the emergent care, until it is determined that the patient can safely travel on a non-emergency basis or the provider is able to get their informed consent to remain at the out-of-network facility despite the fact that they will incur higher cost-sharing.
  - **Qualifying Payment Amount Calculation**
    - No later than 7/1/21, the Secretaries will publish a methodology:
      - By which the qualifying payment amount must be calculated, with different methods for the individual, small, large group, and self-insured markets,
      - To describe the information any plan or issuer must share with an out-of-network provider to accompany their payment in excess of the cost-sharing amount,
      - Any exclusions from the rule that may exist due to geographic reasons, and
      - A process to receive complaints of violations on behalf of plans and issuers.
    - In general, the amount should be:
      - The median amount received by the plan or issuer across all plans offered in the same market (this amount would be gross of the cost-sharing amount that may be the responsibility of the patient), as at 1/31/2019, for the same or similar service, provider, specialty, and geographic region. This amount should be grossed up proportional to the change in CPI for urban consumers.
      - For plans or issuers operating in a market in which they did not participate in 2019, rates will be determined by the Secretaries (forthcoming).
      - In cases where the information is insufficient to produce a fair price, or the procedure is too new, reference should be made to an unbiased database to determine a median price (such as an APCD).

- **Recognized Amount**
  - States determined amounts for care delivered to patients by a non-network individual in a network facility.
  - If in a state with an All-Payer Model Agreement, the amount that the state approves under that system.
  - In the absence of those, the qualifying payment amount.
- **Provision of Services by Non-network Providers (individuals) at In-network Facilities**
  - These providers, who do not receive informed consent before offering their services:
    - Can't impose a cost-sharing requirement on patients that is greater than what the patient would otherwise pay to an in-network individual/provider
    - Must calculate the cost-sharing amount as if the total amount charged was equal to the **recognized amount**
    - Issuers should send initial payment or a notice of denial of payment within 30 days of receiving a bill for the services. Payment should be the excess of the out-of-network rate over the cost-sharing amount. All cost-sharing amounts must apply to in-network deductible/OOP accumulators.
    - Applies to providers not physically located at the facility as well – offsite radiologist professional fees, for example
    - In cases where a sponsor or issuer must access a database to discover the appropriate recognized amount, they can charge a fee to cover the cost of that database access.
- **Choice of Health Care Professional** – Any plan allowing or requiring the selection of a PCP must allow them to choose any available in-network PCP. In the case of a child, this requirement is limited to any physician specializing in pediatrics.
- **Patient Access to OB Care** – Group plans and issuers are prohibited from requiring referrals or prior authorization in the case of a female participant seeking OB/GYN care from an in-network OB/GYN specialist of their choosing. Any items or services ordered by such an OB/GYN should be treated as if they were directly authorized by the PCP**.**
- **Independent Dispute Resolution Process**
  - Open Negotiation
    - In States without laws governing the out-of-network rates as described in Section (a)(3)(K)(ii), the appropriate time to open a discussion to negotiate the bill is in the 30 day period beginning when the issuer or payor sends initial payment or a notice of denial. Either party may initiate the conversation at that time.
  - Accessing Independent Dispute Resolution Process with Failed Negotiations
    - If the 30 days above have lapsed without an agreement, either party has 4 days to notify the other, as well as the Secretary, that they will seek an independent dispute resolution. The content of this communication is to be determined by rulemaking.
  - IDR Process with Failed Open Negotiations
    - Within 1 year of enactment, the Secretaries will publish the process by which a certified IRD entity should determine the amount of the payment for items or services in dispute.
    - If agreement is reached between the parties before a final determination by the IRD, the dispute will settle at that amount, and the IRD will determine how to split fees for work done to that point at their own discretion between both disputing parties.
    - The Secretary will publish criteria under which several similar disputes can be grouped under a single IDR for efficiency. In general, they must be furnished by the same provider, paid by the same plan/issuer, related to the same condition, and all items were within 30 days of the first.
    - IDR entities will be certified by the Secretaries. In general they should have sufficient medical and legal expertise to adjudicate the cases. They cannot be a health plan/issuer or an affiliate or profession/trade association of the same. They must also be clearly able to maintain confidentiality of the information exchanged and demonstrate fiscal integrity. Certifications will last five years and can be revoked at any time, after an investigation requested by the plan, issuer, or provider provided that the Secretary finds evidence of wrongdoing.
    - Each participant to the IDR process has the right to a non-conflicted IRD entity, within the 4-day required period, and the Secretary will develop a process to ensure this is

possible. If by the sixth day, an IRD entity has not been selected, the Secretary will do so in their stead.

- Payment Determination
  - Each party will submit an offer within 10 days of the IRD entity selection as well as any other information determined to be germane to the offer as requested by the IDR. They may also submit extra justification of the amount relating to **additional circumstances**.
  - The IDR should consider the **qualifying payment amount** for the time period, item or service, and geographic region in question as well as **additional circumstances**.
  - **Additional Circumstances** – optional information to be supplied by either side related to level of training, experience, or quality/outcomes of the provider; market share of the provider in the region, the acuity of the individual receiving the service; the complexity of delivering the care to the specific individual; whether the facility is a teaching facility; the case mix and scope of services of the provider; demonstrations of good faith (or lack thereof) in negotiations; and/or any previously negotiated rates with between the entities of the past four years.
  - The IDR should not consider U&C rates; Medicare, Medicaid or other public payer rates; or the rates that would have resulted by following the process for determining balance billing amounts of sections 2799B-1 and 2799B-2 (to follow).
  - The IDR will select the amount on **ONE** of the offers made by the two parties.
- Payment Enforcement
  - The rate determined by the IDR entity will be binding except in cases of fraud or misrepresentation of facts to the IRD. In such cases, judicial review is appropriate.
  - The same initiating party may not make a subsequent IDR request in the 90 days following a prior determination against the same counterparty. They will have 30 days to initiate another request after the 90-day period.
  - Payment for the care will be made within 30 days. The party whose offer was not chose bears 100% of the cost of the IRD process.
- Reporting
  - The Secretary will make a report available on the DHHS site each quarter summarizing the number of disputes, the size of providers submitting disputes, the number of disputes that required an IDR entity to settle the matter, the number of times the amount agreed to exceeded the **qualifying payment amount**, the cost incurred by the Department to facilitate the IDR process, and the total amount of IDR fees paid by disputing parties. Certain information will also be disclosed about each dispute including the description of the item/service, geography of the dispute, the amount offered by each party, type of provider, practice specialty, length of time to reach a determination, and IDR comp.
  - The Secretary will deliver a report to discuss the reality of the 90-day cooling off period – whether it lead to more cooperation or abusive practices, such as routine denial by payors, low payment, down-coding, etc.
- DHHS Fees
  - Any party engaged in a dispute in any year must pay a fixed fee to the Department to cover a share of the costs incurred to adjudicate the dispute process.

- **Balance Billing – Emergency Services**
  - Non-network providers (organizations and individuals) cannot balance bill patients in excess of normal cost sharing amounts as computed above.
- **Balance Billing – Non-Emergency Services**
  - Non-network individuals at network facilities may not balance bill patients in non-emergent settings, unless:
    - The services are ancillary services – emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic services or any other service for which there is no qualified in-network provider on site.
    - The patient is provided notice, and the provider receives consent to be treated by a non-network provider. Adequate notice is 72 hours prior to the time they are expected for their appointment. A patient must be provided a paper or electronic copy of their consent. The notice must:
      - State that the provider is out of network,

        - State that such consent is optional,
        - Be available in the top 15 most common languages for the geographic region,
        - Provide a good faith estimate (but not a guarantee) of the amount to be charged to the patient and that such amount may not apply to plan accumulators,
        - A list of in-network providers in the case where it is only the individual provider who is out of network,
        - Disclosure of any prior auth or other limitations in advance of receiving care,
        - Be retained for seven years by the provider from the date of service.
- **Public Disclosure of Balance Billing Protections**
    - **o** Each provider must make a one-pager available (posted online if possible) stating their requirements applicable to their operation in general from the two sections above, as well as any other applicable state laws applicable billing of non-network patients.
- **Enforcement**
    - o States are initially responsible for enforcement. If the Secretary determines that a state is not enforcing the rules, DHHS will step in to enforce for them. Any state monitoring compliance with the rules may also refer a case to the Secretary for enforcement.
    - o The Secretary may enforce fines of up to $10,000 per violation on providers.
    - o The Secretary will also produce a process by which consumers may make complaints.
    - o Penalties can be avoided if providers withdraw bills and reissue corrected balance bills, refunding any difference paid up to that point plus interest. Applies only in cases where providers do not knowingly violate the rules.
- **Air Ambulance Billing**
    - **o** If air ambulances are covered by the plan in general when in-network, patient cost-sharing amounts will not exceed the amount they might have paid an in-network provider. Any amounts paid by the patient will be counted towards in-network accumulators.
    - **o** Plans and issuers will send initial payment or denial within 30 days of receiving the bill.
    - **o** Same process for determining the payment as was discussed above wrt items and services
    - **o** Independent Dispute Resolution process appears to be identical to above as well.
        - Additional information to be considered by the IRD entity includes vehicle type, including the clinical capability thereof and the population density of the pick-up location.
        - DHHS has the same reporting requirements to disclose IRD process stats as above
    - **o** Same requirement to pay a fee to DHHS for participating in IDR although fee will be different
- **Reporting Requirements for Air Ambulance Services**
    - **o** Each provider of air ambulance services must send to the Secretaries of DHHS and Transportation annually:
        - Cost of providing care, distinguished between operating the aircraft and medical care
        - Number and location of all ambulance bases
        - Number and type of aircraft
        - Number of transports, distinguished by health plans, health insurance issuers, state and federal government payors, and uninsured individuals.
        - Number of denied payments and the reason for denial
        - Number of non-emergency transports arrayed by aircraft type and base
    - **o** Each plan or health insurance issuer must send to the Secretaires of HHS, Labor, and Treasury an annual report showing claims data disaggregated by:
        - Emergency/non-emergency status of the transportation
        - Owner type of service: hospital, municipal, hospital-partnership, independent, tribal
        - Rural or urban pickup
        - Fixed wing or rotor aircraft
        - Contractual vs. non-contractual relationship of payor and provider.
        - Enforceable with a fine of up to $10,000 for failure to cooperate.
    - o Secretaries will publish a report within one year to describe the percent of providers that fall into each ownership category; an assessment of the competition within the market; average changes for the services as well as the average payment by payors/plans vs consumers out of pocket; geographic coverage of air ambulance providers for rural areas; gaps in rural access; percentage of providers with contracts with plans/issuers; patterns of unfair, deceptive, or predatory practices of air ambulance providers; instances of unreasonable industry

concentration, market domination or other conditions allowing a single provider to charge exorbitant rates in a given geography; assessment of the frequency of balance billing, referrals to collections, lawsuits against individuals, liens or wage garnishments; and an analysis of frequency of appeals made by health plans against air ambulance providers bills.
    - A 13-member committee will be established to review options to establish quality, patient safety, and clinical capability standards for each clinical capability level of air ambulances. The committee should produce a report within 180 days of their first meeting for Congress to suggest changes. It should be composed of:
        - Secretary of DHHS or a designee
        - Secretary of Transportation or a designee
        - One person representing each of the following categories – state health insurance regulators, health care providers, group health plans/issuers in the individual market, patient advocacy groups, accredited bodies which assign quality scores
        - Three air ambulance industry representatives
        - Three other individuals not described above assigned by the Secretaries.
- **Deductible and OOP Transparency**
    - **o** All electronic and physical insurance ID cards must show in plain language, the deductible and out of pocket maximum associated with the individual's plan or coverage.
    - **o** Plans and issuers must also make available a telephone number **AND** a website where members may research in-network hospitals and urgent care facilities.
- **Other Reporting**
    - **o** Beginning on 1/1/23 and annually thereafter for four years, HHS, FTC and attorney general produce a report outlining the effects of this Act on vertical/horizontal integration of providers, health plans, or health insurance issuers, overall healthcare costs, access to items and services in rural areas. Make suggestions to deter anti-competitive actions in the market
    - GAO report on the impact of the surprise billing provisions by 1/1/25, to include:
        - Based on a statistically significant sample of providers by survey, an examination of provider network participation, furnishment of services by non-network providers in network facilities, the impact of state laws related to balance billing, and access to providers in rural areas
        - Based on a similar survey of plans/issuers, the effects of the Act on premiums and out-of-pocket costs, the adequacy of provider networks, and categories of ancillary service providers for which plans have a shortage of in-network options.
    - GAO report on the adequacy of provider networks at 1/1/23, including recommendations.
    - GAO report by 12/31/23 on the IDR process and potential financial relationships between providers/facilities using IRD and private equity investment firms.
- **Advanced Cost Estimates - ***STARTING ON 1/1/2022*****
    - Within 1 day of request from a provider or facility offering healthcare services (3 days if the date of service is 10 or more days after the initial request), the plan/issuer must send to the patient, whether or not the provider is in network:
        - The contracted rate for the covered item or service, based on billing info provided by the provider, if in-network, or if a non-network provider, a description of the process to obtain a list of in-network providers,
        - Forward a list of anticipated charges and billing codes prepared by the provider for the incident of care, including any services reasonably expected to be provided in conjunction with the scheduled services. The provider must do this within one day of scheduling if the appointment is made more than three days in advance, and within three days if the appointment is made more than 10 days in advance. If the individual is a self-pay patient, the only requirement is to give this estimate to the individual.
        - A good faith estimate of the amount the plan is responsible for paying
        - A good faith estimate of the amount of cost-sharing expected to be borne by the patient
        - A good faith estimate of amounts already incurred towards deductibles and OOP accumulators for the plan year
        - A disclaimer to the extent that the item or service is subject to a concurrent review, prior authorization step-therapy, or fail-first protocol.
- **Uninsured Patient Dispute Resolution**

    - By 1/1/22 the Secretary will establish a process by which an uninsured patient can dispute final charges, after having first received an estimate of the charges as required above, but then subsequently receives a substantially higher final bill.
        - For the purposes of this section, an uninsured individual includes a person with insurance who chooses not to submit a given claim to their carrier for coverage
    - The Secretary will select a disinterested party to adjudicate the dispute resolution process
    - A small fee will be payable to DHHS for this service
- **Continuity of Care**
    - Beginning 1/1/2022, if during the course of a **continuing care patient**'s treatment, their health plan terminates the contractual relationship with their provider or the plan terminates its relationship with a health insurance issuer offering coverage with respect to the plan, the plan or issuer shall:
        - Notify the individual of the termination and their right to elect continued transition care from the SAME provider
        - Request the patient's transitional care needs
        - Permit the patient to continue using the existing provider for 90 days, or until their need for the care lapses if earlier, at an equivalent cost and subject to the same terms and conditions that would have been if the change in contractual relationships had not occurred.
    - The provider shall accept payment from the plan/issuer plus individual cost-sharing amounts as payment in full and provide care adhering to all policies, procedures, and quality standards imposed by the plan or issuer when there was an active contractual relationship between them, as if the termination had not occurred.
    - **Continuing care patient** is defined as an individual who:
        - Is undergoing treatment for a **serious or complex condition**
        - Is an inpatient or an institutional patient
        - Is scheduled to undergo nonelective surgery from the provider including postoperative care
        - Is pregnant and undergoing treatment related to that pregnancy
        - Is terminally ill and is receiving treatment for their illness
    - A **Series or Complex Condition** is one that:
        - requires specialized treatment to avoid death or permanent harm if acute,
        - is life-threatening, degenerative, potentially disabling, or congenital and requires care over a prolonged period of time if chronic
- **Price Comparison Tool**
    - Plans and issuers must provide price comparison guidance by phone AND a price comparison tool on an internet website allowing a participant to learn and compare cost-sharing amounts that they would be responsible for paying under their plan with respect to a certain item or service and provider.
- **State APCDs**
    - The Secretary will make one-time grants to states to use for the purpose of establishing an APCD or improving an existing APCD.
    - States must submit applications including descriptions of how they will ensure uniform data collection, and the privacy and security of the same.
        - As an aside, they're requiring so much of APCDs with this Act in general, and applying the requirements to self-insured groups, but the vast majority of self-insured claims are excluded from APCDs (where they do exist) because of the Gobeille vs Liberty decision which allowed them to refuse to contribute. Will this Act spur any initiative to change that reality?
    - $2.5MM fixed grant amounts - $1MM in each of the first two years, plus $500K in the final year. In total, $125MM will be phased in for funding these grants between now and 2024. Enough for every state, and the money will stay available until claimed.
    - States taking funds under this grant program must allow access to third parties
        - A research entity must be able to articulate the uses of and methodologies for evaluating health system performance from the data to states' satisfaction. If the research requires IRB approval, access is also contingent on such approval.

        - Employers, health insurance issuers, TPAs, and providers can request data for purposes of quality improvement or cost-containment, with just a description of the intended use
        - All research users must enter a data use agreement with the state
        - Non-customized reports of aggregated data will be available at no cost, while customized reports for employers will be available at cost.
    - State applications will be prioritized if they demonstrate in their application a cooperation with one or more other states, **or if they will implement a reporting format for self-insured group health plans**.
    - Within one year the Secretary will establish a new standardized reporting format for all medical, pharmacy, dental, eligibility, and provider information, and periodically update the same.
        - Within 90 days, the Secretary will nominate a 15-member advisory committee relative to this section to include:
            - Assistant Secretary of the Employee Benefits and Security Administration, or designee
            - Assistant Secretary for Planning and Evaluation of DHHS, or designee
            - A Chair
            - Representative of CMS
            - Representative of the Agency for Healthcare Research and Quality (AHRQ)
            - Representative of the Office of Civil Rights of DHHS, with expertise in privacy and security
            - Representative of the National Center for Health Statistics
            - Representative of the Office of the National Coordinator for Health IT
            - Representative of a state APCD
            - Representative of an employer which sponsors a group health plan
            - Representative of an employee organization that sponsors a group health plan
            - Academic research with expertise in health economics or health services
            - A consumer advocate
            - Two additional members.
        - This committee will produce recommendations for the new file formats within 180 days
        - $5MM budget to establish the committee
- **Improving Accuracy of Provider Directory Information**
    - Database
        - Each plan or issuer must maintain a database on their public website showing each provider or facility with which they have a contractual relationship, including contact info
    - Verification process
        - Each 90 days, each plan or issuer must verify and update their provider directory
            - Must create a process to remove providers for which directory information cannot be reliably verified
        - Must reflect network changes (additions and deletions) within 2 business days
    - Response Protocol
        - If a user requests network information by telephone, plans/issuers must respond within one day and retain a record of the contact for at least two years.
    - To the extent that the plan/issuer publishes a print directory of providers, it must be printed with a statement that the information was accurate only at publishing and to contact for current info.
    - Directory info must include name, address, specialty, phone number, and digital contact info
    - If a participant relied on a provider directory to choose a provider or did not receive a response to their phone inquiry within the allotted one day, and they subsequently consumed care from the provider in question, the plan or issuer must treat the care as if it had been in network with respect to cost-sharing amounts and in-network and OOP accumulators.
- **Ground Ambulances**
    - Within 90 days, the Secretaries will establish a 20+ member committee to review options to improve disclosure of charges and fees for ground ambulances, to better inform consumers of insurance options for those services, and to protect consumers from balance billing.
- **Funding**
    - $500MM to be expended between now and 2024, by DHHS, DoL, and the Treasury. Purposes:
        - Preparing, drafting, and issuing proposed and final regulations

        - Preparing and issuing guidance and public information
        - Preparing and holding public meetings
        - Preparing and publishing reports
        - Enforcement
        - Reporting, collection, and analysis of data
        - Establishing and implementing the independent dispute resolution process
        - Conducting audits
    - The Secretary will make an annual report on the expenditure of these funds – **THAT SHOULD BE INTERESTING**