



Guide to Surprise Billing Provisions in the Consolidated Appropriations Act 2021

The Consolidated Appropriations Act COVID-19 relief bill signed into law on December 27, 2020 is a comprehensive, \$1.4 trillion legislative package that includes COVID-19 related relief for physicians and provides funding for health care related government operations through the end of fiscal year 2021. This new law includes the “No Surprises Act” (the Act), which allows for price transparency, provider directories, and patient financial protections that impact health plans, physicians¹, facilities, and other non-MD/DO licensed health care professionals effective January 1, 2022. The following guide details the important provisions of the Act.

Patient protections (surprise billing)

Scope of Protections

The Act protects patients from surprise medical bills when they receive unanticipated out-of-network care in emergency and nonemergency settings. Specifically, the law applies to out-of-network providers (see footnote 1) and facilities delivering emergency care and out-of-network providers delivering emergency and nonemergency care at in-network facilities. The law also protects patients from surprise bills from out-of-network air ambulance services.

Cost-Sharing

Patients are only responsible for cost-sharing amounts that would be their responsibility if care had been provided in-network. Additionally, providers will be barred from holding patients liable for higher amounts. The patient’s cost-sharing is based on the recognized amount.²

Impact on Uninsured

The Act requires the Secretary of Health and Human Services (HHS) to establish an Independent Dispute Resolution (IDR) process by January 1, 2022 for circumstances in which an uninsured patient’s bill is “substantially in excess” of a good faith estimate. For the purposes of the Act, “uninsured” means that a patient does not have “benefits” for the item or service.

¹ The statute’s use of the term “provider” includes physicians and other non-MD/DO licensed health care professionals.

² The recognized amount is the:

- (1) Amount under specified state law (as applied to plans regulated by state law);
- (2) Qualifying payment amount; or
- (3) If the state has an All-payer model agreement, then the amount the state approves.

The qualifying payment amount in 2022 is the median of the contracted (i.e., in-network) rates as determined by all plans of a plan sponsor or all coverage offered by the health insurance issuer in the same “insurance market” on 1/31/19, increased by the consumer price index for all urban consumers (CPIU).

The qualifying payment amount in 2023 is:

- (1) Based on previous year + CPIU;
- (2) For new plans, the HHS Secretary determines methodology; or
- (3) If there is insufficient info to determine, the plan will use database allowed by Secretary of HHS.

Process for Resolving Payment

There must be an initial payment (determined by the plan) directly from the plan to the provider, or a notice of a denial, within 30-days after the provider transmits the bill to the plan. If the provider is not satisfied with the payment from the plan, they may begin a 30-day open negotiation period. If an agreement cannot be reached in the open negotiation period, the plan or provider has four calendar days to notify the other party and Secretary of HHS that they are initiating an Independent Dispute Resolution process.

Independent Dispute Resolution (IDR)

IDR Process

The IDR process establishes an arbitration procedure that allows independent review of provider-plan disputes. Within three days following the date the IDR process is initiated, the provider and plan must jointly select a certified IDR entity. IDR is initiated when the provider or plan submits a notification to the other party and Secretary of HHS. The parties may continue negotiating during the 30-day IDR process and may agree on a payment amount before the end of the IDR process (in such case both parties will share the cost to compensate the IDR entity). Within 10-days of selecting the IDR entity, the parties must submit final offers, information requested by IDR entity, and additional information (subject to certain exceptions) the parties believe are relevant to their offers.

The party whose offer was not chosen by the IDR entity pays the costs of IDR. Payment for the disputed services must be made to the provider within 30-days of the IDR entity's determination.

Batching is allowed for claims submitted within a 30-day period that meet the following criteria:

- Services furnished by same provider or facility.
- Services provided to patients under the same plan.
- Services are for treatment of similar conditions.

The party that initiated IDR cannot initiate a new IDR process with the same party and for same services for 90 days. However, once the 90-day period is up, the party may submit (appropriately batched) claims from that 90-day period to IDR.

Factors Considered by the IDR Entity

Within 30 days, the IDR entity selects one of the offers submitted and must consider:

- Offers by both parties; and
- Qualifying payment amount (see footnote 2) for the same service in the same geographic region.

The IDR entity can also consider the following factors:

- Training, experience, quality, and outcomes measurements;
- Market shares of parties;
- Acuity of patients/complexity of cases;
- Teaching status, case mix, scope of services of facility; and
- Good faith efforts by parties to contract and contracting rate history from last four years.

The IDR entity cannot consider:

- Usual and customary rates;
- Billed charges; and
- Payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare.

Notice and Consent Requirements for Providers

Out-of-network providers providing scheduled services at in-network facilities may not bill a patient more than the in-network cost-sharing requirements or balance bill the patient unless notice and consent requirements are met.

Such notice and consent requirements are met if:

- The patient is provided written notice and consent 72 hours in advance of appointment.
- Documents provided to patients must include a good faith estimate of the costs of the services (the language specifies this advanced notice does not constitute a contract).
- Patients must also receive a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.

At in-network facilities, the notice and consent exception does not apply to out-of-network providers of radiology, pathology, emergency, anesthesiology, diagnostic, and neonatal services; or to assistant surgeons, hospitalists, intensivists, and providers offering services when no other in-network provider is available.

The Secretary of HHS may apply civil monetary penalties of up to \$10,000 but may provide a hardship exemption or waive the penalties for providers and facilities that did not knowingly violate the requirements laid out under the statute.

Provider Directories

Effective January 1, 2022, health plans must ensure provider directories are current and accurate, with regular verification of provider contract status and updates required at least once every 90 days. Providers are required to submit regular updates to group health plans and insurers to assist with their verification and update process, including notice of material changes to their provider directory information. The database of provider directories must be updated within two business days of the health plan receiving such data.

Health plans must also respond to enrollees about a provider's network status within one business day of a request and establish a database of in-network providers. In addition, they must retain communication records for two years, retain a website directory with contracted providers and relevant information (name, address, specialty, number, digital contact information) and post information on balance billing protections including, if provided under state law, the amount providers/facilities may charge, and appropriate federal and state agency contacts to report violations.

Effective January 1, 2022, providers must have a process in place to ensure timely provision of directory information to a plan. At minimum, the provider must submit directory information when beginning a network agreement, when the provider terminates an agreement, when any material changes (e.g., practice location) are needed to the content of provider directory information, and any other time determined appropriate by Secretary of HHS.

If a patient provides documentation that they received and relied on incorrect information from a plan about a provider's network status prior to a visit, the plan cannot impose a cost-sharing amount greater than in-network rates and it must count toward the patient's in-network out-of-pocket-maximum and in-network deductible. If a provider submits a bill to an enrollee in excess of in-network cost sharing amount and enrollee pays, the provider must refund that excess amount with interest.

All Payer Claims Databases (APCD)

The Act authorizes HHS to make one-time grants to states to establish an All-Payer Claims Database (APCD) or improve an existing one. The grants will be offered for a period of three years for a total of \$2.5 million. States receiving grants will allow access for researchers and entities (including health care providers and plans) for purposes of quality improvement or cost-containment (pending application and approval). HHS may prioritize applicants that will work with other states APCDs to establish a single application for access to data across multiple states. The Secretary will create an advisory committee to establish a standardized reporting format for self-insured plans to submit claims to APCDs.

Additional Transparency and Consumer Protections

Provider Price Transparency

The Act includes provider transparency measures, effective January 1, 2022. Among other provisions, the Act requires an out-of-network provider to deliver to the patient's health plan (or directly to the patient if uninsured) a "good faith estimated amount" of all billing and service codes for all items and services expected to be furnished to the patient, prior to obtaining the patient's consent to treatment. Providers must share these estimates with the relevant party at least three days prior to rendering the scheduled services and within one day of scheduling unless the services are scheduled more than 10 days later (in which case the provider must disclose such information within three business days of scheduling). Furthermore, the HHS Secretary must establish by January 1, 2022 a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.

The Act contains additional new transparency measures, such as mandating that providers make publicly available on their website a short explanation of federal and state requirements and prohibitions related to balance billing. This explanation must include contact information for relevant enforcement agencies aggrieved patients may contact to file complaints.

The HHS Secretary is empowered to establish a formal consumer complaint process through future notice and comment rulemaking, expected within the next six months.

Health Plan Benefits and Price Transparency

The Act implements new requirements for health plans that bolster price transparency and improve consumers' access to health plan information. Beginning January 1, 2022, health plans must provide enrollees with an "Advanced Explanation of Benefits" ("AEOB") prior to scheduled care or upon patient request prior to scheduling. The AEOB requirement is triggered by a provider sending the health plan a "good faith estimated amount" for such scheduled services, and must contain the network status of the provider, information on prior authorizations, estimates of any applicable rates, the enrollee's expected out-of-pocket expenses, the health plan's expected expenses, and the amounts already incurred towards the enrollee's out-of-pocket limits. While a health plan must send the AEOB either within three days of receiving a request or a notice that a service has been scheduled at least 10 business days later, or within one business day of receiving the notice if the service is scheduled within 10 business days of receipt, the Act grants the HHS Secretary the authority to modify such timing for certain services.

Additionally, the Act regulates elements of health plan contracts with both providers and enrollment assistance services. It prohibits "gag clauses" in agreements between health plans and providers that directly or indirectly restrict a health plan from disclosing, or a plan sponsor, referring provider, or group or individual market consumer from accessing, provider-specific price, cost, or quality data. This gag clause prohibition extends to contractual terms that would bar access to de-identified service codes, claims and encounter data, and provider information. The Act permits a provider to place "reasonable restrictions" on the public disclosure of the information subject to the gag clause prohibition; the bounds

of such restrictions remain undefined and subject to interpretation. The Act further regulates health plan contracts by requiring brokers of and consultants to employer-sponsored, individual market, and short-term limited duration health plans to disclose any direct and indirect compensation they may receive for enrollment services.

The Act also imposes new obligations on health plans to report, among other data, plan-specific prescription drug spending and hospital spending information to the HHS, Labor, and Treasury Secretaries. These disclosures will inform new tools detailing drug pricing trends that will be published on the HHS website and made available to consumers.

Transparency Regarding In-Network and Out-of-Network Deductibles and Out-of-Pocket Limitations

A group health plan or a health insurance issuer offering group health insurance coverage and providing or covering any benefit with respect to items or services shall include, in clear writing, on any physical or electronic plan or insurance identification card issued to the participants or beneficiaries in the plan or coverage the following: any applicable deductible, any out-of-pocket maximum limitation, and a phone number and website through which consumer assistance may be sought.

Patient Financial Protections

Protecting Patients and Improving the Accuracy of Provider Directory Information

As noted earlier, additional provider directory information is required to improve accuracy and protect patients including establishing a verification process, response protocol, and a more detailed database.

Continuity of Care

If a provider contract is terminated without cause, a “continuing patient” can continue to receive services from the newly excluded provider for either 90 days or the date when the services are no longer needed, whichever is earlier.

State Law Implications

The intent of the law is not to preempt state surprise billing laws. However, there is some ambiguity in the statutory language that will require further clarification before and during the rulemaking process, including when the surprise billing protections apply to patients in self-funded ERISA plans. The AMA will work with Federation members and other stakeholders to seek clarification to address these ambiguities and will provide updates as new information becomes available.

Required Reports

- HHS report with the Federal Trade Commission and U.S Attorney General on effects of the Act on integration, costs, and access.
- Government Accountability Office (GAO) report on impact of surprise billing changes on networks, access, premiums, out-of-pocket costs.
- GAO report on network adequacy.
- GAO report on IDR and potential financial relationships.

Effective Dates

The No Surprises Act goes into effect on January 1, 2022, including the following:

- The Secretary of HHS must establish the IDR process to resolve surprise medical billing disputes.

- The Secretary of HHS must establish a dispute resolution process for when an uninsured patient's bill is "substantially in excess" of the good faith estimate.
- Health plans must ensure provider directories are current and accurate, with regular verification of provider contract status and updates required at least once every 90 days.
- Providers and facilities must have a practice in place to ensure timely provision of directory information to a plan.
- Health plans must provide enrollees with "Advanced Explanation of Benefits" ("AEOB") prior to scheduled care or upon patient request prior to scheduling.