Congress Passes the No Surprises Act as Part of the Consolidated Appropriations Act, 2021

Part 1

President Trump Signs Act into Law

Updated 12/28/2020

5-Minute Read

On December 28, 2020, President Trump signed the Consolidated Appropriations Act, 2021 (Appropriations Act), which includes the No Surprises Act (Act), into law. President Trump initially refused to sign the Appropriations Act until amended to increase the COVID-19 stimulus payment from $600 to $2,000, but signed the legislation, in part, to avoid a government shutdown. The legislation includes roughly $900 billion in COVID-19 relief, including a number of provisions beneficial to hospitals and health systems. The No Surprises Act seeks to protect consumers from surprise medical bills for emergency services provided by out-of-network providers and facilities, non-emergency services provided by out-of-network providers at in-network facilities, and air ambulance services. The Act also establishes other means for protecting consumers. The Act amends Title XXVII of the Public Health Service Act (PHSA), Part 7 of Title I of the Employee Retirement Income Security Act of 1974 (ERISA), and Chapter 100 of the Internal Revenue Code of 1986 (IRC), effective for plan years beginning on or after January 1, 2022, unless otherwise noted. The Act applies to group health plans or health insurance issuers offering group or individual health insurance coverage and healthcare providers and facilities. This Advisor provides a high-level summary of the No Surprises Act, which will be supplemented as additional guidance develops.

Preventing Surprise Medical Bills

Emergency Services

Under the Act, group health plans, or health insurance issuers offering group or individual health insurance coverage, that provide or cover any benefits with respect to services in an emergency department of a hospital (this includes a hospital outpatient department that provides emergency services) or an independent freestanding emergency department (in-network or out-of-network, also referred to as participating and non-participating), the plan or issuer must cover the emergency services without the need for any prior authorization determination and without regard to any other term or condition of such coverage. Exceptions include exclusion or coordination of benefits, or an affiliation or waiting period, permitted under the Patient Protection and Affordable Care Act (ACA), and incorporated pursuant to ERISA and the Internal Revenue Code, and other applicable cost-sharing.

If the emergency services are provided by a non-participating provider or non-participating emergency facility, the plan or issuer must cover the emergency services subject to several requirements. For example, requirements for prior authorization or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities cannot be imposed. In addition, there can be no cost-sharing that is greater than the requirement that would apply if the emergency services were provided by a participating provider or a participating emergency facility. The cost-sharing requirement is calculated as if the total amount that would have been charged for emergency services by the participating provider or participating emergency facility were equal to the recognized amount (the amount specified by state law, or a qualifying payment amount, or an amount determined under an All-Payer Model Agreement entered into by the state) for the services, plan or coverage, and year.

Services Furnished by a Non-Participating Provider

In the event services are provided by a nonparticipating provider (e.g., physician) at a participating facility or at a nonparticipating emergency facility, providers may not bill beyond an allowed cost-sharing amount (based on the recognized amount). In addition, 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 from when the provider transmits the bill to the plan. If the provider is not satisfied with the payment from the plan, the parties 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 days to notify the other party and the Secretary of the Department of Health and Human Services (HHS) that they are initiating the Independent Dispute Resolution (IDR) process.

Ending Surprise Air Ambulance Bills

For air ambulance services furnished by a non-participating provider that would be covered if provided by a participating provider, the plan or issuer must:

- Impose the same cost-sharing requirement for the air ambulance services that would apply had the services been furnished by a participating provider. Any coinsurance or deductible must be based on rates that would apply for the services had they been furnished by a participating provider.

- Provide an initial payment or notice of denial of payment within 30 days after the bill for the services is transmitted by the provider.

- Pay a total plan or coverage payment directly to the provider within 30 days after determination of the payment amount is made (see the section on determination below) with application of any initial payment, equal to the amount by which the out-of-network rate for the services exceeds the cost-sharing amount for the services and year.

- Count any cost-sharing payments made by an individual covered under the plan with respect to the services toward any in network deductible or out-of-pocket maximums applied under the plan or coverage (and in-network deductible and out-of-pocket maximums must be applied) in the same manner as if the cost-sharing payments were made for items or services furnished by a participating provider.

Each health plan and health insurance issuer must submit a report to HHS no later than 90 days after the last day of the first calendar year beginning after the date on which HHS finalizes a rule implementing the Act and no later than 90 days after the last day of the calendar year immediately following the plan year.

Audit Process and Regulations for Qualifying Payment Amounts

The Act instructs HHS to issue regulations by October 1, 2021, to provide an audit process under which group health plans and health insurance issuers offering group or individual health insurance coverage will be audited to ensure the plans and coverage are correctly calculating the qualifying payment amount for items and services. Under the Act, HHS may audit any group health plan or health insurance issuer if HHS has received any complaint or other information about a plan or coverage regarding their compliance with the qualifying payment amount requirement.

The Act also instructs HHS to issue regulations by July 1, 2021, to establish the methodology that group health plans and health insurance issuers must use to determine the qualifying payment amount, the information plans and issuers must share with out-of-network providers or facilities when determining the qualifying payment amount, the geographic regions applied, and a process to receive complaints of violations of the qualifying payment requirement.

Determination of Out-of-Network Rates to be Paid by Health Plans and Independent Dispute Resolution Process

Under the Act, if an item or service is furnished by a non-participating provider or a non-participating facility for a group health plan or health insurance issuer in a state that does not have a specified law that determines the price for an item or service that a health plan or issuer must pay, the provider or facility may initiate open negotiations within 30 days beginning on the day the provider or facility receives an initial payment or a notice of denial of payment from the plan or coverage to determine an agreed upon amount (including any cost-sharing) for the item or service. The open negotiations may last no longer than 30 days beginning on the day the negotiations were initiated for the item or service. If open negotiations do not result in an agreed-upon amount of payment for the item or service by the last day of open negotiations, the provider or facility, or group health plan or health insurance issuer, may initiate an IDR process during the four-day period beginning on the day after the open negotiation period ended. The independent resolution process must be initiated by providing notice to the other party and to HHS (the notice must contain information as specified by HHS). The parties may agree on a payment amount before the certified entity for the independent resolution process has determined the amount. Under the

Act, HHS, the Department of Labor (DOL), and the IRS are to issue regulations to govern this process within one year of enactment of the law.

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

Under the Act, a group health plan or health insurance issuer offering group or individual health insurance coverage must include the following information on any physical or electronic plan or insurance identification card issued to participants, beneficiaries, or enrollees under the plan:

- Any deductible applicable to the plan or coverage
- Any out-of-pocket maximum limitation applicable to the plan or coverage
- A telephone number and Internet website address through which an individual may seek consumer assistance information

Maintenance of a Price Comparison Tool

A group health plan or health insurance issuer offering group or individual health insurance must offer price comparison guidance by telephone and provide a price comparison tool on the Internet website of the plan or issuer that allows an individual enrolled under the plan or coverage to compare the amount of cost-sharing that the individual would be responsible for regarding a specified item or service by any of the providers, with respect to the plan year, geographic region, and participating providers,.

Provider Directory Information

Beginning January 1, 2022, health insurers, health plans and other coverage providers (coverage provider) must establish a database and disclose on its website, each provider and facility (and directory information) with which it has a contractual relationship for furnishing items or services, including contact information for each provider and facility. The coverage provider must establish a verification process that verifies and updates the database described below at least every 90 days, removes a provider or facility that is unable to be verified. A response protocol is also required to be established which requires that health service recipients receive responses to telephone calls within one day after requesting information on whether a provider or facility has a contractual relationship with the plan or issuer for furnishing items or services.

If a participant or beneficiary was furnished an item or service from a non-participating provider or facility in reliance on incorrect information in the database regarding the provider's participation status, the plan or issuer must not impose a cost-sharing amount for the item or service that is greater than the cost-sharing amount that would apply had the item or service been furnished by a participating provider and apply the deductible or out-of-pocket maximum that would apply had the item or service been furnished by a participating provider or facility.

Disclosure of Billing Protections

For plan years beginning January 1, 2022, plans and issuers must disclose the requirements and prohibitions against balance (surprise) billing, any state law requirements regarding balance billing, and contact information for the appropriate state and federal agencies that may be contacted by individuals that believe a provider or facility has violated the prohibitions against balance billing. This information is

required to be made publicly available, posted on a public website, and is required to include and explanation of benefits for emergency services and non-emergency services that are subject to the requirements preventing balance billing.

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