



## **AMA High-Level Summary of the No Surprises Act**

### **General structure: patient protections against surprise medical bills and determining out-of-network provider payments:**

- For services provided by a nonparticipating provider (e.g., physician) at a participating facility or at a nonparticipating emergency facility:
  - Providers may not bill beyond allowed cost-sharing amount (this amount is based on the recognized amount).
  - 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, 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 4 days to notify other party and Secretary of HHS that they are initiating the Independent Dispute Resolution (IDR) process.
  
- IDR Structure:
  - The provider or plan have a 30-day window from the day the provider “receives an initial payment or notice of denial of payment” from the plan to initiate the open negotiation period.
  - If the provider and plan cannot reach an agreement by the end of the 30-day open negotiation period, the plan or provider may initiate IDR during the 4-day period after the open negotiation period ends.
  - IDR is initiated when the provider or plan submits a notification to the other party and Secretary of HHS.
  - Within three-business days following the date the IDR was initiated, the provider and plan jointly select a certified IDR entity.
  - The parties may continue negotiating during the 30-day IDR process, and may agree on an amount of payment 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 IDR entity being selected, the parties must submit final offers, information requested by IDR entity, and any information (except and noted below) the parties would like related to their offers.
  - Within 30 days, the IDR entity selects one of the offers submitted and must consider:
    - Offers by both parties.
    - Qualifying payment amount (for the same service in the same geographic region)
    - Circumstances:
      - Training, experience, quality and outcomes measurements.
      - Market shares of parities.

- Acuity of patients/complexity of cases.
  - Teaching status, case mix, scope of services of facility.
  - Good faith efforts by parties to contract and contracting rate history from last four years.
- The provider and plan may also submit other information relating to such an offer submitted by either party.
- The IDR entity cannot consider usual and customary rates or billed charges.
- The IDR entity also cannot consider the payment rates by public payors, including Medicare, Medicaid, CHIP, and Tricare rates.
- The party whose offer was not chosen by the IDR entity, pays the costs of IDR.
- Payment 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:
  - Services furnished by same provider or facility.
  - Services provided to patients under the same plan.
  - Services are for treatment of similar conditions.
  - The Secretary to specify criteria and may allow exceptions to 30-day period.
- The party that initiated IDR cannot initiate it again 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.
- HHS to publicly report on IDR use and outcomes, including the identity of health plans, providers, and facilities that use the process. The Secretary must ensure that there is no release of confidential or privileged information.
- Parties that use the IDR process will be required to pay an administrative fee to the Secretary each year. (The amount to be established by Secretary)
- Definitions:
  - Recognized amount:
    - Amount under specified state law (as applied to plans regulated by state law);
    - Qualifying payment amount; or
    - If the state has an All-payer model agreement, then the amount the state approves.
  - Qualifying payment amount:
    - For 2022, 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).
    - In 2023, based on previous year + CPIU.
    - For new plans: Secretary determines methodology.
    - Insufficient info to determine: Plan to use database allowed by Secretary.
  - Out of network rate:
    - If specified in state law, then the state determines rate.

- If no state law, then either agreed upon amount between the provider and plan or the IDR-determined amount.
  - If state law has All-payer model agreement, then that amount.
- Emergency services definition includes services provided after patient is stabilized if certain conditions are met.
- Specified state law: a state law that provides for method to pay providers in these situations for service provided.
- Insurance market is one of the following:
  - The individual market;
  - The large group market;
  - The small group market; or
  - A self-insured group health plan, other self-insured group health plans.

**Notice and consent provisions for balance billing of non-emergency services by non-participating providers at participating facilities)**

- Non-participating providers at participating facilities may not bill a patient more than the cost-sharing requirements or balance bill the patient unless the notice and consent requirements are met.
- 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).
  - Must also provide a list of in-network providers at the facility and information regarding medical care management, such as prior authorization.
- At participating facilities, the notice and consent exception does not apply to out-of-network providers of radiology, pathology, emergency, anesthesiology, diagnostic and neonatal services; assistant surgeons, hospitalists, intensivists, and providers offering services when no other in-network provider is available.
- The Secretary may apply civil monetary penalties of up to \$10,000 but may provide a hardship exemption or waive the penalties if the provider did not knowingly violate law and corrects with interest.

**Provider Directories**

- By 2022, plans must:
  - At least every 90 days, verify and update directories.
  - Establish procedure for removing providers unable to verify.
  - Update provider information within 2 business days of receiving it from a provider.
  - Respond to request regarding network status of provider within 1 business day and retain communication for 2 years.

- Retain website directory with contracted providers and directory information (name, address, specialty, number, digital contact information).
- 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.
- By 2022, providers and facilities must:
  - Have a practice in place to ensure timely provision of directory information to a plan.
  - At minimum, the provider must submit to the plan:
    - When the provider begins a network agreement with a plan with respect to certain coverage.
    - When the provider terminates an agreement.
    - Any material changes to the content of provider directory information.
    - Any other time determined appropriate by Secretary.
- If a patient relies on erroneous directory information, 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.
  - It is expected that the provider will be paid the previously contracted rate (assuming a contract was previously in place).
  - If a provider submits a bill to an enrollee in excess of in-network cost sharing and enrollee pays, provider must refund with interest.

### **All payer claims databases (APCDs)**

- Grants will be made available to states establish an APCD or improve existing one. The grants will be offered for a period of 3 years for 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.
  - HHS may prioritize applications submitted by states that will implement format for self-insured group health plans (Section 735 of ERISA).
- The Secretary will create an advisory committee to establish a standardized reporting format for reporting by self-insured plans to submit claims to APCDs. Format to be established 1 year after enactment.

### **Reports**

- HHS report with the Federal Trade Commission and U.S Attorney General on effects of 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.

### **Other provisions**

- Legislation addresses surprise bills for **air ambulances**.
- **Dispute resolution for uninsured:**
  - HHS Secretary will establish a dispute resolution process by July 21, 2021 for when an uninsured patient’s bill is “substantially in excess” of good faith estimate.
  - “Uninsured” means that a patient does not have “benefits” for the item or service.
- **Continuity of care:**
  - If provider contract is terminated, a “continuing patient” can continue for either 90 days or the date when no longer a continuing patient, whichever is earlier.
  - The provider must continue under same terms and conditions.
  - This provision does not apply to for-cause terminations (provider fails to meet quality standards or commits fraud).
- **Price comparison tool:** A plan must offer price comparison guidance by phone and make tool available on internet that allows patients to compare cost-sharing amounts for specific service/item.
- HHS must issue a proposed rule implementing section 2706(a) of the Public Health Service Act regarding **protections against provider discrimination** within six months of implementation, and a final rule six months after the 60-day comment period of the proposed rule.
- **Insurance cards** to include deductible, out-of-pocket maximum, phone number, and website for assistance.
- A plan must provide an **advanced explanation of benefits** in advance of the service containing the following information:
  - Whether the provider or facility is participating and, if so, the contracted rate.
  - If the provider or facility is out-of-network:
    - Information on how patient can find info on contracted physicians at facility;
    - The good faith estimate from the provider, if applicable;
    - A good faith estimate of the amount the plan is responsible for paying;
    - A good faith estimate of cost-sharing based on provider’s estimate and the amount to be applied to the patient’s out-of-pocket maximum and deductible;
    - A disclaimer that coverage is subject to medical management requirements, if applicable;
    - A disclaimer that the information is only an estimate and may be subject to change;
    - A statement that the patient may seek care from a participating provider or at facility.