

February 2, 2021

**ILLINOIS HEALTH AND HOSPITAL ASSOCIATION  
M E M O R A N D U M**

**SUBJECT: Federal “No Surprises Act” Addresses Surprise Billing – IHA Summary**

As part of the [Consolidated Appropriations Act of 2021](#), the No Surprises Act, found on page 1629, outlines new patient protections from surprise medical bills and new requirements for healthcare providers and plans. The provisions apply to both state-regulated individual and group health plans and self-funded Employee Retirement Income Security Act (ERISA) plans. Most provisions in the Act are effective January 1, 2022 and provide for regulations to be issued.

It is important to note that the Act does not impose a government-set benchmark rate to determine out-of-network payment reimbursement nor allow the dispute resolution process to consider government reimbursement rates, which is a positive outcome. IHA advocated against these provisions with the Illinois congressional delegation. The Act does require hospitals to provide good faith charge estimates, however, it is unclear whether this is for all scheduled services or only upon patient request. IHA will provide input on this and other issues as regulations develop.

**Outline of Major Provisions**

Emergency Department (ED), Cost Sharing and Payment

If a health plan covers emergency services, then it shall cover all emergency services provided in a hospital ED or a free-standing ED without prior authorization and without regard to whether the facility participates in the patient’s health plan. It shall not apply any greater restrictions or cost sharing than imposed for in-network emergency services and any such cost sharing shall count toward the patient’s in-network deductible and out-of-pocket maximum. Cost sharing includes copayment, coinsurance and deductibles. An out-of-network provider must bill services directly to the patient’s health plan, and may not bill the patient directly. The health plan then has 30 days from the bill date to either pay or deny the claim. If paid, the payment must go to the provider, not the patient.

The patient’s cost sharing amount is calculated from the recognized amount, which is defined as either the amount recognized under any applicable state law that applies to this situation, the amount established through an all-payer rate-setting model, e.g., Maryland’s model, or the qualifying payment amount. By July 1, 2021, issued regulations will outline how to calculate the qualified payment amount taking into account a number of aspects outlined in the law. The qualifying payment amount is based on historic rates between the health plan and the provider. If historic information is not available, then the qualifying payment is based on the median contract rate recognized by the health plan on January 31, 2019 within the same market and

increased by the consumer price index year-over-year, but does not consider Medicare Advantage plans within the determination. If the plan was not available in 2019, then the qualifying amount would be the median contract rate from the first plan year offering coverage of the service or information from an independent database, such as an all-payer claims database.

The Act defines out-of-network rate as either the amount provided under state law for a non-participating provider, the amount agreed to between the health plan and provider, or the amount determined under the Independent Dispute Resolution process.

#### Non-emergency Services by Non-Participating Providers at Participating Facilities

The same protections and payment determinations apply to services received at an in-network facility by an out-of-network provider. One limited exception is if the out-of-network provider obtained consent from the patient, outlined in greater detail in a separate section and summarized below under Notice and Consent Exemption.

Pediatricians are allowed to be a child’s primary care physician and plans must provide enrollees access to obstetrical and gynecological care without implementing a prior approval process.

#### Independent Dispute Resolution (IDR) Process

A provider that receives an initial payment or denial from a health plan for out-of-network services may either accept the payment or open negotiations with the health plan during a 30-day period that begins with receipt of the initial payment or denial. If negotiations fail, either party may request the Independent Dispute Resolution (IDR) process during the four days after the initial 30-day negotiation period. This is termed the notification. The parties then have three days to jointly choose an IDR entity, or if they cannot, the Secretary of Health and Human Services (HHS) will choose one. The provider and health plan may continue negotiating during the IDR process, and if an agreement is reached, the parties split the IDR fees. Providers may batch together disputed claims that occur during a 30-day period. Regulations on the IDR process are due by December 27, 2021.

HHS will develop a process to certify IDR entities, as well as a process for parties to petition for revocation of such certification if the entity fails to meet any of the certification requirements outlined in the law. IDR entities must have relevant medical and legal expertise, have the ability to make timely determinations, and cannot be biased, e.g., cannot be a health plan, provider or association of providers or health plans. IDR entity certification lasts 5 years.

Ten days after a certified IDR entity is selected, the provider and health plan must submit their best payment offer with supporting documentation, a process often called baseball style arbitration. The IDR entity will select one of the offers after taking into consideration a number of factors outlined in the Act, such as geographic region, market share, training and experience

of the provider, and patient acuity. The IDR entity shall not consider usual and customary charges or rates paid by public programs. The losing party is responsible for all fees associated with the IDR process, and once a determination is made the payer has 30 days to provide the agreed reimbursement to the provider.

The IDR entity’s decision is binding and not subject to judicial review. The party that submitted the notification to start the IDR process cannot submit another claim for the same services with the other party during the 90-day period after the initial notification. The HHS Secretary, in consultation with Labor and Treasury Secretaries, shall examine the implementation of this provision and submit a report to Congress on whether any health plan has a pattern of routine denial or low reimbursement, or otherwise abuses the 90-day clause.

Starting in 2022, the HHS Secretary shall make information regarding this process public on a quarterly basis, including: number of IDR notifications submitted, size of the providers submitting notifications, number of cases in which the IDR made a determination, cost of the IDR process, description and geographic location of services in dispute, offers from each party, percentage related to the qualifying amount of each offer submitted, identity of the health plans and providers involved in IDR processes, type of providers involved, length of time for the resolution, and IDR entity compensation.

#### Health Care Provider Requirements

Effective January 1, 2022, any out-of-network healthcare providers shall not bill any patient for covered emergency services and certain non-emergency services provided by in-network facilities greater than what would be billed if the hospital or provider were in-network. There is a limited exception to this if the provider gives notice and receives consent to balance bill. However, this exception cannot apply to emergency, anesthesiology, pathology, radiology, laboratory and neonatology services, and items and services provided by assistant surgeons, hospitalists, intensivists, and such other items and services the HHS Secretary specifies in rules. It also cannot apply to a non-participating provider at a participating facility if there is no participating provider able to provide the service at the facility. The HHS Secretary may develop a list of advanced diagnostic laboratory tests that would not be included in the above. The exception also does not apply in situations in which items and services are provided as a result of an unforeseen, urgent medical need that arises at the time a covered service is provided.

#### Notice and Consent Exemption

The written paper or electronic notice and consent provision must be obtained within 72 hours of the provision of the item or service, or at the time the appointment is made if the service is scheduled within the next 72 hours. The notice needs to outline that the consent to receive services from an out-of-network provider is optional and the patient may seek care from a participating provider or facility. The notice must be available in the 15 most common languages spoken in the area and the HHS Secretary will issue further guidance by July 1, 2021. The notice must contain the following information: the provider is non-participating (out-of-

network); a good faith estimate of the charges; if the facility is participating but the provider is non-participating, it must include a list of any participating providers that could provide the service to which the patient could be referred to; and information on prior authorization or other care limitations that might apply in advance of receiving these services.

The HHS Secretary shall develop a form for the patient’s signature that acknowledges: they have been provided with the written notice outlined above; the charges may not apply to their cost-sharing requirements; the date they received the notice; and the date of the patient consent. The document must be kept by the non-participating facility or participating facility that has non-participating providers for seven years.

Effective January 1, 2022, all providers must make publicly available, post on their website, and provide to insured individuals a one-page notice, via postal or electronic as specified by the insured individual, regarding the balance billing information in the law, any state-level information related to balance billing and how to contact state and federal agencies to report any violations.

#### Enforcement

Each state may require providers to be in compliance with the provisions in the Act. If a state does not enforce any violation, the Secretaries of HHS, Labor and Treasury have enforcement authority and HHS can impose a fine of \$10,000 per violation. The penalties can be waived if the provider unknowingly violated the provisions, withdraws the difference between the amount billed and allowed, and refunds the patient or plan with interest. The Secretary may also issue a hardship exemption. A federal consumer complaint process will be established.

#### Air Ambulance Bills

The Act outlines similar provisions, effective January 1, 2022, to protect patients from receiving surprise bills from out-of-network air ambulances. Air ambulance is defined as medical transport by helicopter or airplane for patients. The Act requires that the insured patient shall not have cost-sharing obligations greater than if the air ambulance was in-network and the cost-sharing shall count toward their in-network cost-sharing responsibilities. The health plan has 30 days from the issuance of a bill to either issue a denial or send a payment. There is a 30-day negotiation period starting from the date of denial or received payment. If there is no resolution, either the health plan or provider can initiate the IDR process similar to that laid out for other providers. Similar public reporting provisions are included related to IDR process and determinations.

The Act establishes new air ambulance data reporting requirements to the HHS Secretary and Secretary of Transportation. Information to be submitted includes: cost data separated between air transport and medical services provided; payer mix; number of claim denials; claims separated by emergent and non-emergent; ownership of the air ambulance provider; and other information. HHS and Transportation must issue rules to govern report requirements

and public reports within one year of enactment, and reporting requirements would begin 90 days after the final rule. The HHS Secretary will issue a public report summarizing the information received as well as information related to competition among air ambulance providers, geographic coverage, average charges, claim denials by health plans, patient billing and collection practices. Air ambulances that do not submit the required information are subject to a \$10,000 civil monetary penalty.

An Advisory Committee on Air Ambulance Quality and Patient Safety will be established to review and make recommendations to Congress on quality, safety and clinical capability level of air ambulances.

#### Health Plan Transparency Requirements

Health plans are required to include on all beneficiary ID cards: the deductible, out-of-pocket maximum limitation, telephone number and the website where further beneficiary information can be found related to the plan and in-network providers.

#### Provider Discrimination

Rules are to be issued to implement changes made by the Affordable Care Act regarding protections against provider discrimination. Under these protections, health plans cannot discriminate against providers acting within the scope of their license. Additionally, health plans do not have to contract with any willing provider and they can establish varying reimbursement rates.

#### Reports related to the No Surprises Act

By January 1, 2023 and for four subsequent years, various federal agencies are required to develop reports related to the impact of the Act on health plans and providers and implications for healthcare costs and the cost or and access to healthcare. The Government Accountability Office (GAO) is required to issue several reports. By January 1, 2023, the GAO shall submit legislative recommendations to improve network adequacy, and by December 31, 2023, it shall issue a report that reviews the IDR process. By January 1, 2025, it shall report on the impact of this Act on provider networks, specialty care and out-of-pocket costs.

#### Advance Cost Estimates and Health Plan Advance Explanation of Benefits

Effective January 1, 2022, each provider and healthcare facility must provide a good faith estimate of charges, including ancillary services and services that are reasonably expected to be provided by another health care provider, as well as related billing and diagnostic codes, for scheduled items or services. These estimates are to go to the health plan if the individual is insured or to the individual if uninsured. This estimate is required when the service is scheduled at least three days in advance or upon request. The estimate is due at least three business days before the service is furnished and no later than one business day after scheduling. However, if the service is scheduled more than 10 days in advance, then the estimate is due within three business days from when the service is scheduled or from when

the patient requested the estimate. It is somewhat unclear if this estimate is needed for all scheduled services or only upon a patient’s request. This will be an area that needs further clarification in regulation.

Beginning January 1, 2022, when a health plan receives a good faith estimate from a provider, it triggers the health plan to issue an Advanced Explanation of Benefits (EOB). The plan must issue the Advanced EOB before services are furnished. A patient may also request an Advanced EOB. The EOB will include eight components:

- Whether the provider is participating for that service, and if participating, then it will state what the contracted rate is for that service. If the provider is not participating, it will state how the patient can get information on participating providers that could provide that service.
- The good faith estimate received from the provider.
- A good faith estimate of what the plan will pay.
- A good faith estimate of what the patient’s payment responsibility will be.
- A good faith estimate of where the patient stands with respect to their out-of-pocket responsibilities under their health plan.
- A disclaimer related to whether the service is subject to medical management, such as prior authorization.
- A disclaimer that the information is only an estimate based on the information supplied and may be subject to change.
- Any other information or disclaimers deemed appropriate by the health plan.

Plans must issue an Advanced EOB within three business days of receiving a patient request or a notice of a scheduled service when the service is scheduled at least 10 business days after the notice. If the service is scheduled less than 10 days after the notice, the health plan must provide the Advanced EOB within one business day. HHS can modify this timeline if the service has low utilization or significant variation in costs.

#### Uninsured Patient Dispute Resolution Related to a Price Estimate

By January 1, 2022, the HHS Secretary shall develop a patient-provider dispute resolution process for an uninsured patient who received a bill with charges substantially in excess of the estimate. Regulations will include a method for selecting and certifying IDR entities and fees, however the fee shall not create a barrier for an uninsured patient to participate in the process.

#### Continuity of Care

The Act requires health plans to allow a “continuing care patient” to continue to receive care at in-network cost sharing from their provider for 90 days if the in-network provider decides to leave the provider network. A continuing care patient is defined as one who is undergoing treatment for a serious or complex condition, is undergoing a course of institutional or inpatient care, is scheduled for non-elective surgery and post-op care, is pregnant and undergoing treatment, or is terminally ill and undergoing treatment. Serious and complex

condition is defined as: in the case of an acute illness, a condition that is serious enough to require specialized medical treatment to avoid the reasonable possibility of death or permanent harm; or in the case of a chronic illness or condition, a condition that (i) is life-threatening, degenerative, potentially disabling, or congenital and (ii) requires specialized medical care over a prolonged period of time.

#### Health Plan Price Comparison Tool

The Act requires health plans to have a price comparison tool on their website, and provide the information by phone, that allows an individual enrolled in the health plan to compare the amount of cost sharing for items and services by participating providers.

#### State All Payer Claims Databases

The HHS Secretary will make one-time grants to eligible states to create or improve All Payer Claims Databases (APCD). Grants will be awarded based on an application process and provide \$2.5 million over three years. HHS will develop application requirements and the data must be made available at no charge for researchers and others such as employers and healthcare providers for the purpose of quality improvement or cost containment. Within one year HHS will establish a reporting format for voluntary reporting by health plans of claims data. Within 90 days HHS will establish an Advisory Committee to provide advice on this format with a report due within 180 days.

#### Health Plan Provider Directories

For plan years beginning on or after January 1, 2022, health plans must have a process to verify and update provider directories every 90 days. Plans must also have a protocol for responding to inquiries about provider network status and maintenance of a public database on contracted providers and facilities and provider directory information for each such provider and facility.

If a patient relied on information in the provider directory or information provided via phone as to the participation status of a provider or facility and that information was not accurate, the patient would only be subject to cost sharing responsibilities for participating providers. Health plans must also provide information regarding balance billing protections.

#### Ground Ambulance Advisory Committee

Within 90 days of enactment, an advisory committee on ground ambulance billing will be formed to review options to improve disclosure of charges and fees for ground ambulances, better inform consumers of insurance options for these services, and protect consumers from balance billing. A report is due with recommendations 180 days after the first meeting.

If you have any questions, please [contact IHA](#).