

Summary of the No Surprises Act (H.R. 133, P.L. 116-260)

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Introductory Note. For ease of reading, the term “health plan” refers to group health plans and group and individual health insurance coverage offered by health insurance issuers, and includes insured and self-insured plans, unless otherwise specified; “participating” and “nonparticipating” providers/facilities are sometimes referred to as out-of-network (OON) providers/facilities; and “enrollee” is shorthand for participant, beneficiary, or enrollee. Many of the sections of the No Surprises Act summarized below provide for identical or nearly identical additions to the Public Health Service Act (PHS Act), Employee Retirement Income Security Act (ERISA) and the Internal Revenue Code (IRC). In this way, the provisions of the Act are applied to group and individual health insurance coverage offered by health insurance issuers (PHS Act), private-sector group health plans (e.g., employer-sponsored and union-sponsored group health plans (ERISA and the IRC). Accordingly, reference to “the Secretary” is generally meant in this summary to include the Secretary of Health and Human Services, the Secretary of Labor, and the Secretary of the Treasury. They will have to coordinate to implement, administer and enforce many of the provisions of the No Surprises Act.

A “*Glossary of Terms and Acronyms*” is included at the end of the summary.

Short Title

“No Surprises Act” included in the Consolidated Appropriations Act, 2021, Public Law 116-260.

Unless otherwise indicated, provisions are effective for plan years beginning on or after January 1, 2022.

Overview

The No Surprises Act amends the Public Health Service Act (PHS Act), Employee Retirement Income Security Act (ERISA), the Internal Revenue Code (IRC), and the law governing the Federal Employees Health Benefits Program (FEHBP) to prohibit surprise bills (including both out-of-network (OON) cost sharing and balance billing amounts) for individuals covered by group health plans and health insurance issuers of group and individual health insurance coverage when: (1) receiving emergency services (and post-stabilization services) furnished by a nonparticipating provider or nonparticipating facility and (2) when receiving non-emergency services, furnished by nonparticipating providers in participating facilities. Exceptions may apply for post-stabilization and nonemergency services if certain conditions are met—for example, if the individual is provided with a compliant notice and consents to receiving non-emergency services from nonparticipating providers and to paying the OON cost sharing and balance billing amounts.

In addition, the Act protects enrollees against surprise billing if the enrollee relied on inaccurate provider network status information in the health plan’s directory about a provider when obtaining care.

No payment standard “benchmark” is established for amounts to be paid to nonparticipating facilities or providers affected by the surprise billing prohibitions. The Act instead calls for a 30-day period for negotiation between providers/facilities and health plans with a backstop of an Independent Dispute Resolution (IDR) process to resolve payment disagreements between the parties. A State will be able to determine its own methods for compensating health care providers with respect to a surprise bill to the extent that a State regulates the applicable health plan. (Under ERISA, States are generally preempted from regulating private sector, group health plans.)

The IDR process to be established under the Act will be conducted by a certified IDR entity, which will resolve claims disputes between nonparticipating providers and facilities and health plans that are not resolved within the 30-day negotiation period. The losing party will pay the costs. An administrative fee is to be established by the Secretary to

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participate in the IDR system. Not later than 30 days after the selection of the IDR entity, the entity will select one of the offers submitted by the parties as the payment amount and notify the provider or facility and the health plan party to such determination of the offer selected.

For uninsured individuals, the Secretary of HHS is required to establish a patient-provider dispute resolution process if the patient is billed substantially in excess of the provider's good faith estimated charges.

The Act also includes transparency sections regarding provider directories; furnishing advance cost estimates and estimated out-of-pocket (OOP) costs for specific services; health plan maintenance of a provider price comparison tool; and disclosure of cost sharing and certain provider information on health plan identification cards.

The surprise billing provisions will apply with respect to plan years beginning on or after January 1, 2022.

Implementation Funding

The No Surprises Act appropriates to the Secretaries of HHS, Labor and Treasury a total of \$500 million for fiscal year 2021, to remain available until expended through 2024, for preparing, drafting, and issuing proposed and final regulations; preparing, drafting and issuing guidance and public information; preparing and holding public meetings; preparing, drafting and publishing reports; enforcement; reporting, collection, and analysis of data; establishment and initial implementation of the processes for IDR and implementation of patient-provider dispute resolution; conducting audits; and other administrative duties necessary for implementation. Each Secretary is required to annually submit a report on expended funds to the House Committees on Energy and Commerce, Ways and Means, Education and Labor, and Appropriations and the Senate Committees on HELP and Appropriations. (sec. 118 of the bill)

Plan Applicability, and Scope of Enrollee Protections Against Surprise Bills

Applicability to Health Plans and Health Insurers

The No Surprises Act applies to participants, beneficiaries and enrollees in group health plans and group and individual health insurance coverage offered by health insurance issuers. The law also applies to grandfathered health plans (as defined in section 1251(a) of the Affordable Care Act).

By definition in underlying law, "individual health insurance coverage" does not include short-term, limited-duration plans. Underlying law also excludes "excepted benefits," such as standalone dental or vision plans.

ERISA and IRC. New sections are added to ERISA and to the IRC to apply the provisions of the law to group health plans and to group health insurance coverage offered by health insurance issuers.

Non-federal governmental health plans. By applying the surprise billing and other provisions of the Act to existing sections of the PHS Act, it applies those provisions to both insured and self-insured State and local governmental health plans.

Health Savings Accounts (HSAs). The Act provides that an individual shall not fail to be treated as an eligible individual for an HSA for any period merely because that individual receives benefits for medical care subject to and in accordance with the law's prohibition on surprise medical bills. In addition, a health plan does not fail to be treated as a high deductible health plan by reason of providing benefits for medical care in accordance with the law's surprise billing prohibitions or any State law providing similar protections to individuals prior to the satisfaction of the deductible under the plan (see 102(a)(4) of the bill).

FEHBP plans. Under the Act, any health benefits offered by a FEHBP plan are to be treated as a group health plan or group or individual health insurance coverage for purposes of the law's surprise billing provisions. The surprise billing

protections are also applied to health care providers and facilities and air ambulance providers with respect to an enrollee in a FEHBP plan. (sec. 102(d)(1) of the bill)

Scope of balance billing prohibition and required in-network cost sharing: emergency services

The law's provisions apply to emergency medical services furnished at a nonparticipating emergency facility (hospital department or independent freestanding facility) or by a nonparticipating provider at a participating emergency facility (i.e., an emergency department of a hospital or independent freestanding emergency department).

If a health plan provides or covers any benefits with respect to emergency services in a hospital emergency department or an independent freestanding emergency department, it must cover those emergency services: (i) without the need for any prior authorization determination, (ii) whether the provider or facility is or is not participating and, (iii) if nonparticipating, covers those services without imposing any prior authorization requirement or any limitation on coverage that is more restrictive than the requirements or limitations applicable to emergency services received from participating providers and facilities. (new secs. 2799A-1(a) of the PHS Act; 716 of ERISA and 9816 of IRC).

Scope of balance billing prohibition and required in-network cost sharing: non-emergency services

(See also "*Notice and consent requirement exception*" below, which includes other circumstances)

The No Surprises Act applies the balance billing prohibition and in-network cost-sharing requirement in the case of non-emergency services furnished by nonparticipating providers for a visit by an enrollee at participating facilities unless required notice and consent have been met. It defines a participating facility as a health care facility that has a direct or indirect contractual relationship with the health plan with respect to furnishing the item or service at the facility. A health care facility in this context includes a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center or any other facility, specified by the Secretary, that provides items or services for which coverage is provided under the health plan. Qualified items and services furnished to an individual during a visit to a health care facility include: equipment and devices, telemedicine services, laboratory services, preoperative and postoperative services, and such other items and services as the Secretary may specify regardless of whether or not the provider furnishing the items or services is at the facility. (new secs. 2799A-1(b)(2) of PHS Act, 716(b)(2) of ERISA, and 9816(b)(2) of IRC).

Enrollee Safeguards

Enrollee hold harmless safeguards against OON cost sharing by health plans

Under the No Surprises Act, plan enrollee cost sharing (expressed as a copayment, coinsurance, and deductible) will be limited to amounts that would apply if the services had been furnished by a participating provider (or facility in the case of emergency services).

The nonparticipating provider or nonparticipating facility is prohibited from billing or holding liable the enrollee for costs beyond in-network cost sharing.

Plan enrollee cost sharing will be calculated as if the contracted rate for the services, if furnished by a participating provider (or facility, in the case of emergency services) is equal to the recognized amount. The recognized amount is defined as the amount defined under State law, where applicable; the amount designated under an All-Payer Model Agreement; or the qualifying payment amount, which is generally the median contracted rate. (See also "*Treatment of Payment Amounts to OON Providers and Facilities*" below.) (new secs. 2799A-1(b)(1) of the PHS Act, 716(b)(1) of ERISA, 9816(b)(1) of IRC)

Any cost-sharing payments made by the enrollee for an item or service must be counted toward any in-network deductible and in-network out-of-pocket maximum applied under the health plan in the same manner as if such cost-

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sharing payments were made with respect to such items and services furnished by a participating provider. (new secs. 2799A-1(b)(1) of the PHS Act, 716(b)(1) of ERISA and 9816(b)(1) of IRC)

Reliance on Incorrect Provider Information. The Act limits cost sharing to the amount that would have applied if the nonparticipating provider or nonparticipating facility was a participating provider if the enrollee demonstrates that they relied on the health plan's provider directory and that information turned out to be incorrect. In this situation, the applicable deductible or out-of-pocket maximum, if any, would apply as if such services were furnished by a participating provider or a participating facility. (See also below "*Requirements on health plans to disclose balance billing prohibitions and network and cost-sharing information to enrollees.*")

Notice and consent requirement exception: post-stabilization

The No Surprises Act provides for certain exceptions to the balance billing protections if the enrollee receiving emergency or post-stabilization services consents to receive such services from a nonparticipating provider. OON cost sharing (including any balance bills) applies to OON post-stabilization services if an enrollee is given a compliant notice and then provides written consent to bear responsibility for OON amounts. These provisions are applied to the OON facility or OON provider and to the enrollee's health plan. Specifically, OON cost sharing will apply to OON post-stabilization services, furnished on an inpatient or outpatient basis, if the individual is stable and the provider or facility determines that the individual is able to travel using nonmedical transportation or non-emergency medical transportation; the provider furnishing the additional items and services satisfies the notice and consent criteria; the individual is in a condition to receive the information and to provide informed consent (in accordance with State law) and such other conditions as specified by the Secretary, such as conditions relating to coordinating care transitions to participating providers and facilities.

Notice and consent requirement exception: non-emergency services

The Act also provides for exceptions to the balance billing protections if the enrollee receiving non-emergency services (other than ancillary services) from a nonparticipating provider consents to receive those services from that provider. If an enrollee is given a compliant notice by the nonparticipating provider and the enrollee provides written consent to bear responsibility for OON amounts, then OON cost sharing (including any balance bills) will apply with respect to the enrollee and their health plan. Ancillary services include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology whether or not provided by a physician or nonphysician practitioner, and items and services provided by assistant surgeons, hospitalists and intensivists.

The notice and consent exception does not apply if the furnished service results from unforeseen, urgent medical needs arising at the time of the service. (new sec. 2799B-2(c) of the PHS Act)

Providers furnishing non-emergency services may request an exception through notice and consent unless they are one of the following specialties: emergency medicine providers or suppliers, anesthesiologists, pathologists, radiologists, neonatologists, assistant surgeons, hospitalists, intensivists, or other providers determined by the Secretary. (new sec. 2799(B2)(b) of the PHS Act)

The Act also states that the notice and consent exception does not apply to a nonparticipating health care provider if there is no participating provider at a participating facility who can furnish the item or service. (new sec. 2799(B2)(b) of the PHS Act)

The Act permits the Secretary, through rulemaking, to establish a list (and update it periodically) of advanced diagnostic laboratory tests, which are not to be included as an ancillary service (see above) but to which the balance billing prohibition would apply. (new sec. 2799B-2(a)(3) of the PHS Act)

Nature and content of notice and consent

(See also below “Requirements on providers to disclose cost sharing/ balance billing to their patients”)

The No Surprises Act provides that the notice and consent requirement is satisfied by a nonparticipating provider or nonparticipating facility if that provider or facility obtains the required consent from the enrollee or their authorized representative not later than 72 hours prior to the date of the delivery of the items or services. This requirement is also satisfied if the notice and consent is given on the date of the appointment if the enrollee makes an appointment within 72 hours of the furnishing of the items or services. The notice and consent must be written (paper or electronic form, as selected by the enrollee, including electronic notification, as practicable) consistent with specifications issued through guidance by the Secretary not later than July 1, 2021. This guidance is to be updated as determined necessary by the Secretary. The notice must contain certain information (see below); clearly state that consent is optional; and that the person may instead seek care from a participating provider or participating facility, with respect to their particular health plan. In addition, the notice must also state that if the enrollee obtains the services from a participating provider or facility, that their cost sharing cannot exceed the cost sharing applicable if the item or service is furnished by a participating provider or participating facility. The notice must be available in the 15 most common languages in the geographic region of the facility. The provider or facility must obtain from the enrollee the required consent (see below) to be treated by the nonparticipating provider or facility and provide a signed copy of the consent to the enrollee through the mail or email (as selected by that enrollee).

Information required under written notice. The notice must include: (i) that the provider or facility is nonparticipating with respect to the health plan; (ii) a good faith estimated amount that the provider or facility may charge the enrollee including a notification that the provision of the estimate or the consent to be treated does not constitute a contract with respect to those estimated charges; (iii) a list of any participating providers at the facility who are able to furnish the items and services involved and that the enrollee may be referred, at their option, to that provider; and (iv) information about whether prior authorization or other care management limitations may be required in advance of receiving the items or services at the facility.

In addition, the required signed consent by the person must be provided (through use of a document specified in guidance by the Secretary of HHS, in consultation with the Secretary of Labor) before the items or services are furnished. The consent form must acknowledge in clear and understandable language that the person: (i) has been provided with the written notice (as specified above); (ii) informed that the payment of the charge by the person may not accrue toward meeting any limitation that the health plan places on cost sharing, including an explanation that the payment may not apply to the in-network deductible or their health plan, (iii) provided the opportunity to receive the written notice in the form selected by the enrollee; and (iv) documents the date of receipt of the written notice and date on which the enrollee signed the consent.

The Act states that this consent constitutes only consent to the receipt of the information provided pursuant to this section of the law and does not constitute a contractual agreement of the enrollee to any estimated charge or amount included in the information.

Retention of Written Notices. A nonparticipating facility (or any nonparticipating provider at the facility) or a participating facility (with respect to nonparticipating providers) that obtains from an enrollee a written notice, as described above, is required to retain the written notice for at least a 7-year period after the date on which the item or service is furnished. (new secs. 2799B-2(b)(a) through € of the PHS Act)

External review in cases of surprise medical bills

Under the No Surprises Act, enrollees have access to the current law independent appeal process. This is done by an amendment to section 2791(b)(1) of the PHS Act to provide the external review process with respect to any adverse

health plan determination relating to surprise medical billing (as established under the Act) including, with respect to whether an item or service that is subject to a health plan determination, is subject to independent external review. (sec. 110 of the bill)

Requirement for Plan Payments or Denial of Payment

Not later than 30 calendar days after the bill for items or services is transmitted by the provider or facility, the health plan is required to send to that provider or facility an initial payment or notice of denial of payment.

The health plan is required to directly pay the nonparticipating provider or facility a total health plan payment, which is the amount by which the OON rate determined in IDR or negotiation exceeds the cost-sharing amount under the health plan. (See “Treatment of Payment Amounts to OON Providers and Facilities” below.) The payment must be made not later than 30 days after a determination in IDR or negotiation. [new secs. 2799A-1(c)(6) of the PHS Act, 716(c)(6) of ERISA, 9816(c)(6) of IRC].

Interaction of cost sharing/balance billing provisions with State laws

The No Surprises Act incorporates underlying section 2724 of the PHS Act that preserves State flexibility in this regard except to the extent that such standard or requirement prevents the application of the Act.

In addition, by incorporating underlying section 2724 of the PHS Act, the No Surprises Act makes clear that it does not affect or modify the provisions of section 514 of ERISA with respect to group health plans (i.e., federal preemption of State laws relating to private sector, employee benefits plans that include group health plans).

Applicable Transportation Providers Covered by Surprise Billing Enrollee Protections

Ground ambulance services

Not later than 90 days after enactment, the Secretaries of Labor, HHS, and Treasury are required to jointly establish an advisory committee to review options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for those services, and protect consumers from balance billing. The No Surprises Act specifies the composition of the committee. In addition, it requires the committee to consult with relevant experts and stakeholders while conducting the review and make recommendations with respect to disclosure of charges and fees for ground ambulance services and insurance coverage, consumer protection and enforcement authorities of the three Departments and the prevention of balance billing to consumers. The recommendations must address, at a minimum: (1) options, best practices, and identified standards to prevent instances of balance billing; (2) steps that can be taken by State legislatures, State insurance regulators, State attorneys general, and other State officials as appropriate, consistent with current legal authorities regarding consumer protection; and (3) legislative options for Congress to prevent balance billing.

Not later than 180 days after the date of its first meeting, the advisory committee must submit to the Secretaries and the House Committees on Education and Labor, Energy and Commerce, and Ways and Means and the Senate Committees on Finance and HELP, a report containing its recommendations. (sec. 106(g) of the bill)

Air ambulances: surprise billing protection

The No Surprises Act adds new provisions to the PHS Act, ERISA and the IRC to prohibit surprise air ambulance bills. This consumer protection will apply in the case of an enrollee in a health plan who receives air ambulance services (i.e., medical transport by helicopter or airplane) from a nonparticipating provider. The Act prohibits an air ambulance provider from billing or holding liable an enrollee for a payment amount for its air ambulance service that is more than the cost-sharing amount for that service if the provider were participating in the coverage or plan. (sec. 105 of the bill)

Cost sharing. Under the Act, cost sharing for air ambulance services provided by a nonparticipating provider must be the same as if provided by a participating provider and any coinsurance or deductible be based on rates that would apply if the services were furnished by a participating provider. Further, any cost-sharing amounts must be counted toward the plan's in-network deductible and in-network out-of-pocket maximum amount for the plan year. Any such in-network deductible must be applied in the same manner as if such cost-sharing payments were furnished by a participating provider. The health plan is required to pay a total plan payment directly to the provider furnishing the services that is, with the application of any initial payment, equal to the amount by which the OON rate for such services and year involved exceeds the plan's in-network cost-sharing amount for air ambulance services. The initial payment must be made (or notice of denial of payment provided) not later than 30 days after the bill is transmitted by the provider to the health plan. (new secs. 2799A-2(a) of the PHS Act, 717(a) of ERISA, 9817(a) of IRC)

Air ambulances: cost reporting requirements

Required cost reporting by air ambulance providers. Beginning on or after the date a final rule is promulgated, an air ambulance provider is required to submit to the Secretaries of HHS and Transportation within 90 days after the last day of the first calendar year and within 90 days after the last day of the succeeding plan year, for the respective plan year: (i) cost data, as determined appropriate by the Secretary of HHS, in consultation with the Secretary of Transportation, for air ambulance services furnished by the provider, separated to the maximum extent possible by air transportation costs associated with furnishing such air ambulance services and costs of medical services and supplies associated with furnishing such air ambulance services; (ii) the number and location of all air ambulance bases operated by such provider; (iii) the number and type of aircraft operated by such provider; (iv) the number of air ambulance transports, disaggregated by payor mix, including group health plans, health insurance issuers, State and federal government payors, and uninsured individuals; (v) the number of claims of such provider that have been denied payment by a health plan and the reasons for any such denials; (vi) the number of emergency and non-emergency air ambulance transports, disaggregated by air ambulance base and type of aircraft; and (vii) such other information regarding air ambulance services as the Secretary of HHS may specify. (sec. 106(a) of the bill)

Reporting requirements on health plans. The Act requires each health plan to submit to the Secretary of HHS, jointly with the Secretaries of Labor and Treasury, not later than 90 days after the last day of the first calendar year beginning on or after the date of the promulgation of the final rule claims data for air ambulance services furnished by providers of those services, disaggregated by: (i) whether the services were furnished on an emergent or nonemergent basis; (ii) whether the provider is part of a hospital-owned or sponsored program, municipality-sponsored program, hospital independent partnership (hybrid) program, independent program or tribally operated program in Alaska; (iii) whether the services furnished originated in a rural or urban area; (iv) the type of aircraft (such as rotor transport or fixed wing transport) used to furnish the services; (v) whether the provider has a contract with the health plan; and (vi) such other information regarding providers of air ambulance services as the Secretary of HHS may specify. (sec. 106(b) of the bill)

Comprehensive Secretarial Report. By not later than one year after the promulgation of a rule, the Secretary of HHS, in consultation with the Secretary of Transportation, is required to develop and make publicly available a comprehensive report summarizing the information submitted under the above provisions. The Act specifies in detail the types of information to be included, such as the percentage of providers of air ambulance services that are part of a hospital-owned or sponsored program. The Secretaries may incorporate information from independent experts or third-party sources in developing the comprehensive report. The Act prohibits the Secretaries from making publicly available any proprietary information. (sec. 106(c) of the bill)

Rulemaking. Not later than one year after enactment, the Secretary of HHS, in consultation with the Secretary of Transportation, through notice and comment rulemaking, must specify the form and manner for the above reports to be submitted to the Secretaries, taking into consideration (as applicable and to the extent feasible) any recommendations

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included in the report submitted by the Advisory Committee on Air Ambulance and Patient Billing under section 418(e) of the FAA Reauthorization Act of 2018 (Public Law 115–254; 49 U.S.C. 42301 note prec.). (sec. 106(d) of the bill)

Enforcement. The Act provides for a civil money penalty (CMP) of up to \$10,000 per violation of its requirements that the air ambulance provider submit the specified information (e.g., cost data and location of all air ambulance bases operated by the provider). An exception to this penalty is available upon waiver by the Secretary that the air ambulance provider demonstrates a good faith effort in working with the Secretary to provide the required remaining information. The Act calls for the application of the provisions of section 1128A of the SSA, with certain exceptions, in the imposing of CMPs under this section. (sec. 106(e) of the bill)

Unfair and deceptive practices and unfair methods of competition. The Act permits the Secretary of Transportation to use any information submitted under the above requirement in determining whether a provider of air ambulance services has violated the section of the US Code relating to complaints about air carrier (including air ambulance) unfair and deceptive practices and unfair methods of competition. (sec 106(f) of the bill)

Air ambulance: quality and patient safety

Advisory Committee on Air Ambulance Quality and Patient Safety. Not later than 60 days after enactment, the Secretary of HHS and the Secretary of Transportation, are required to establish an Advisory Committee on Air Ambulance Quality and Patient Safety to review options to establish quality, patient safety, service reliability, and clinical capability standards for each clinical capability level of air ambulances. The Act specifies the membership features of the Advisory Committee. It requires the first meeting to occur not later than 90 days after enactment and that the Committee study and make recommendations to Congress regarding specified aspects of air ambulance services such as the qualifications of different clinical capability levels and tiering of such levels and patient safety and protocol standards. By not later than 180 days after enactment, the Committee, in consultation with relevant experts and stakeholders, must develop and make publicly available a report on any recommendations submitted to Congress. The Committee may update the report as it determines appropriate. (sec 106(g) of the bill)

Treatment of Payment Amounts to OON Providers and Facilities

In general

The No Surprises Act does not include a benchmark or standard for determination of an OON payment rate for payments from health plans to OON providers or facilities. It provides instead for such a rate to be determined through open negotiations and, if that fails, through IDR. For States with laws in place, the Act provides for deference to State rules on establishing payment amounts, including those States with a payment standard. The Act does include payment standards to be used as a factor in the IDR process and as the basis for calculating in-network cost sharing.

Qualifying Payment Amount

For an item or service furnished during 2022, the qualifying payment amount is defined as the median of the contracted rates under the plans on January 31, 2019, for the same or similar specialty and provided in the geographic region in which the item or service is furnished (consistent with the methodology established by the Secretary). The contracted rate is based on the total maximum payment (including the cost-sharing amount and the amount to be paid by the health plan). The median contracted rate is determined with respect to all health plans within the same insurance market (i.e. individual, large group, small group or, in the case of a self-insured group health plan, other self-insured group health plans) as the plan. For 2022, the 2019 amount is increased by the percentage increase in the CPI-U over 2019, 2020, and 2021. For an item or service furnished after 2022, the 2022 amount is to be increased by the percentage increase in the CPI-U over the previous year. (new secs. 2799A-1(a)(3)(E) of the PHS Act; 716(a)(1)(3) of ERISA and 9816(a)(3)(E) of the IRC)

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Qualifying payment amounts for new plans and coverage. With respect to a health plan in a geographic region in which the plan did not offer any coverage during 2019, the qualifying payment amount is defined—(1) for the first year in which the health plan is offered in a region, a rate (determined in accordance with a methodology established by the Secretary) for the items or services furnished in the first year; and (2) for subsequent years for that region, the qualifying payment amount is increased by the percentage increase in the CPI-U over the previous year. (new secs. 2799A-1(a)(3)(E) of the PHS Act; 716(a)(1)(3) of ERISA; and 9816(a)(3)(E) of the IRC.)

Qualifying payment amounts in case of insufficient information. If a health plan lacks sufficient information to calculate a median contracted rate for 2019 (or in the case of a newly covered item or service, for the first coverage year), the qualifying payment amount is to be calculated through the use of any database that is determined, in accordance with rulemaking, to be free of any conflicts of interest and with sufficient information reflecting allowed amounts paid to a provider or facility for relevant services furnished in the applicable geographic region (such as a State all-payer claims database). The qualifying payment amount for an item or service furnished in a subsequent year (before the first sufficient information year) is to be increased by the percentage increase in the CPI-U over such previous year. The rate for subsequent payment years after 2022 is to be treated as the first year after the first sufficient information year or subsequent year. (new secs. 2799A-1(a)(3)(E) of the PHS Act; 716(a)(1)(3)(E) of ERISA; and 9816(a)(3)(E) of IRC.)

Qualifying payment amounts for newly covered items and services. For an item or service for which coverage is not offered in 2019 under the health plan, the *first coverage year* is the first year after 2019 for which coverage for an item or service is offered under the plan. (new secs. 2799A-1(a)(3)(E) of the PHS Act; 716(a)(3)(E) of ERISA; and 9816(a)(3)(E) of the IRC) For an item or service for which the plan does not have sufficient information to calculate the median of the contracted rates in 2019, the first year subsequent to 2022 that should be used is the one for which the sponsor has sufficient information to calculate the median of the contracted rates in the year previous to the first such subsequent year. (new secs. 2799A-1(a)(3)(E) of the PHS Act; 716(a)(3)(E) of ERISA; and 9816(a)(3)(E) of the IRC.) A “newly covered item or service” is one which was not offered in 2019 but is offered under the health plan in a year after 2019. (new secs. 2799A-1(a)(3)(E) of the PHS Act, 716(a)(3)(E) of ERISA and 9816(a)(3)(E) of the IRC)

Access Fees to Data Bases. The Act requires the health plan to cover the cost of accessing a database to determine an applicable payment rate in a situation where it has insufficient information with respect to an item or service. (new secs. 2799A-1(c) of the PHS Act, 716(c) of ERISA and 9816(c) of the IRC)

Audit process and regulations for qualifying payment amounts. By October 1, 2021, the Secretary, in consultation with the Secretaries of Labor and Treasury, is required to establish through rulemaking a process under which health plans are audited by the Secretary or applicable State authority to ensure that the plans comply with the Act’s qualifying payment amount requirements.

The Secretary is required to conduct audits with respect to a year (beginning with 2022) of a sample with respect to that year of claims data from not more than 25 health plans and may audit any health plan if the Secretary has received a complaint or other information about such health plan that involves compliance with the qualifying payment amount requirements. (new secs. 2799A-1(a)(2)(A) of the PHS Act 9816(a)(2) of IRC)

Regulations for Qualifying Payment Amounts. By July 1, 2021, the Secretary of HHS, in consultation with the Secretaries of Labor and Treasury, must establish through rulemaking: (i) the methodology the health plan must use to determine the qualifying payment amount, differentiating by individual market, large group market and small group market; (ii) the information the health plan must share with the nonparticipating provider or nonparticipating facility when making such a determination; (iii) the geographic regions applied, taking into account access to items and services in rural and underserved areas, including health professional shortage areas; and (iv) a process to receive complaints of violations of the requirements relating to the qualifying payment amount by health plans. This rulemaking must take into account payments made by the health plan not on a fee-for-service basis. The methodology may account for relevant payment

adjustments accounting for quality or facility type (including higher acuity settings and the case-mix of various facility types) that are otherwise taken into account to determine facility payment amounts. The Secretary is required to consult with the National Association of Insurance Commissioners (NAIC) to establish the geographic regions and periodically update such regions, as appropriate, taking into account the findings of the report submitted under section 109(a) of the No Surprises Act (relating to a mandated report on the impacts of the No Surprises Act on various aspects of the healthcare delivery system - see “*Additional required federal agency reports and studies*” below).

Recognized Amount

The Act refers to the “recognized amount” to mean, with respect to an item or service furnished by a nonparticipating provider or nonparticipating emergency facility during a year and a health plan –

- In a State with a “specified State law” (see below) with respect to the health plan, the nonparticipating provider or nonparticipating emergency facility, and the item or service, the amount determined in accordance with State law;
- In a State without a State law, the amount that is the qualifying payment amount for the year and determined in accordance with rulemaking for that item or service; or
- In the case of an item or service furnished in a State with an All-Payer Model Agreement under section 1115A of the Social Security Act, the amount that State approves under that all-payer system for the item or service. (new secs. 2799A-1(a)(3)(H) of the PHS Act, 716(a)(3)(H) of ERISA, and 9816(a)(3)(H) of IRC)

Specified State Law. The Act uses this term to mean a State law that provides for a method for determining the amount of payment that is required to be covered by the health plan (to the extent that the law applies, subject to section 514 of ERISA) for an enrollee receiving the item or service from a nonparticipating provider or emergency facility (secs. 2799A-1(a)(3)(I), 716(a)(3)(I) of ERISA, 9816(a)(3)(I) of IRC). (Section 514 of ERISA generally provides for federal preemption of State laws relating to private-sector employee benefit plans which include group health plans.) (new secs. 2799A-1(a)(2)(B) of the PHS Act, 716 (a)(2) of ERISA and 9816(a)(2)(B) of IRC.)

Out-of-network rate

The Act provides that the rate for an item or service furnished to an enrollee by a nonparticipating provider or emergency facility in a State during a year is—

- Determined according to State law that provides for a method for determining the total amount;
- The amount agreed upon through open negotiations between the plan and provider or facility in the case of a State without such State law in effect, if the provider or facility and health plan agree on a payment amount, or the amount determined by the IDR process if the provider or facility and plan enter into such a process (See “*Negotiations to Determine a Payment Amount*” and “*Independent Dispute Resolution to Determine a Payment Amount*” below) and do not agree on the amount before the date on which a selected certified IDR entity makes a determination; or
- The amount that the State approves under an All-Payer Model Agreement under section 1115A of the SSA, if one exists. (new secs. 2799A-1(a)(3)(K), 716(a)(3)(K) of ERISA, 9816(a)(3)(K) of IRC)

Negotiations to Determine a Payment Amount

In general

Under the No Surprises Act, the nonparticipating provider or nonparticipating facility or the health plan (referred to as a “party”) may open a 30-day negotiation period to determine a payment amount. During the negotiation period, the health plan is not allowed to stop payment to a provider or facility. Certain information must be exchanged between the parties during the open negotiation period.

Negotiation period

Unless a State has a law applicable to OON rates in the case of balance bills, the nonparticipating provider or nonparticipating facility or the health plan may initiate open negotiations to determine a payment amount (including any cost sharing) that is agreed to by the parties. The 30-day open negotiation period begins on the day the provider or facility receives a response from the plan regarding a claim for payment. (new secs. 2799A-1(c)(1) of the PHS Act, 716(c)(1) of ERISA; 9816(c)(1) of IRC)

Independent Dispute Resolution (IDR) to Determine a Payment Amount

In general

The No Surprises Act calls for the establishment of an IDR Process and provides for certification of IDR entities. Not later than one year after enactment, the Secretary is required to establish the IDR process, which will determine the amount of payment for an item or service furnished in applicable surprise billing situations. The process provides for a baseball style of arbitration, meaning that the IDR entity must select one of the offers submitted by the parties. The parties retain the possibility of reaching a settlement before IDR is completed. There is no IDR threshold. (new sec. 2799A-1(c)(5)(E) of the PHS Act, 716(c)(5)(E) of ERISA, 9816(c)(5)(E) of IRC)

Waiver Authority. The Act authorizes the Secretary to modify any deadline or other IDR process timing (other than with respect to the establishment date for the IDR process or the timing of payments to providers after IDR or negotiation is complete) in cases of extenuating circumstances (as specified by the Secretary) or to ensure that all claims that occur during the 90-day period when a notification is not permitted to be submitted, are eligible for the IDR process. (new secs. 2799A-1(c)(9) of PHS Act, 716(c)(9) of ERISA, and 9816(c)(9) of IRC)

Interaction with State provider payment and dispute resolution laws

The No Surprises Act preserves a State's ability to determine its own payment standards for health plans regulated by the State. In addition, if the State has in place certain All Payer Model Agreements, then the amount approved under that system applies in lieu of the federal payment standard.

Initiation of IDR

If the negotiation fails during the 30-day period, a party to the negotiations (which may be a nonparticipating provider, a nonparticipating emergency facility or a health plan) may, during the 4-day period beginning on the day after the end of the open negotiation period, initiate the IDR process by submitting the required information (as specified by the Secretary) to the other party and to the Secretary. The date of initiation of the IDR process is the date of the submission or such other date specified by the Secretary (pursuant to regulations) that is not later than the date of receipt of the notification by both the other party and the Secretary. (new secs. 2799A-1(c)(B)(1) of PHS Act, 716(c)(1)(B) of ERISA and 9816(c)(1)(B) of IRC)

The Act clarifies that a nonparticipating provider may not, with respect to an item or service that it has furnished, submit a notification seeking IDR if the provider is exempt from the requirement because the item or service was not for an emergency and the provider satisfied compliant notice and consent. (under new subsection(a) of 2799B-2)

The Secretary is required to provide for a method that allows the parties to jointly select, not later than the last day of the 3-day period following the date of the initiation of the IDR process, a certified IDR entity that is not a party to such determination or an employee or agent of the party; does not have a material familial, financial, or professional relationship with the party; and does not otherwise have a conflict of interest with the party (as determined by the Secretary). If the parties fail to make a selection by the last day, the Secretary, not later than 6 business days after the initiation date, must select an entity that meets these criteria and notify the provider or facility and the health plan. An

entity selected to make a determination is called a “selected IDR entity” with respect to that determination. (new secs. 2799A-1(c)(4)(F) of the PHS Act; 716(c)(4)(F) of ERISA and 9816(c)(4)(F) of IRC)

Certification of IDR Entities

The Act requires the Secretary of HHS, in consultation with the Secretaries of Labor and Treasury, to establish a process to certify (including recertification of) IDR entities and to ensure that an entity that is certified: (i) has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make determinations on a timely basis; (ii) is not a health plan; an affiliate or a subsidiary of a health plan, provider, or facility; or an affiliate or subsidiary of a professional or trade association of health plans or health insurers or of providers or facilities; (iii) carries out the bill’s prescribed responsibilities; (iv) meets appropriate indicators of fiscal integrity; (v) maintains the confidentiality (in accordance with regulations promulgated by the Secretary) of individually identifiable health information obtained in the course of conducting such determinations; (vi) does not under the IDR process carry out any determination with respect to which the entity would not be authorized by the bill; and (vii) meets other requirement as determined appropriate by the Secretary. (new secs. 2799A-1(c)(4)(A) of the PHS Act, 716(c)(4)(A) of ERISA, 9816(c)(4)(A) of IRC)

The IDR certification (or recertification) is to be for a period of 5 years. A certification can be revoked if the entity has a pattern or practice of noncompliance with any of the bill’s applicable requirements. The process must ensure that an individual, provider, facility, or health plan may petition for a denial of a certification or a revocation of a certification with respect to an entity for failure to meet a requirement.

Finally, a sufficient number of entities must be certified to ensure the timely and efficient provision of determinations. (new secs. 2799A-1(c)(4)(B), (C), (D) and (E) of the PHS Act, 716(c)(4)(B), (C), (D) and (E) of ERISA, 9816(c)(4)(B), (C), (D) and (E) of IRC)

Costs of IDR Process

Under the Act, the non-prevailing party is required to pay all fees charged by the IDR entity. If the parties reach a settlement to IDR, the costs must be divided equally between the parties, unless the parties otherwise agree. (new secs. 2799A-1(c)(5)(E) of the PHS Act, 716(c)(5)(E) of ERISA, 9816(c)(5)(E) of IRC)

Administrative fee. The Secretary is required to establish an annual fee to participate in the IDR process so that the total amount of fees paid for the year is estimated to be equal to the amount of expenditures estimated to be made by the Secretary for each year in carrying out the IDR process. (new secs. 2799A-1(c)(8) of the PHS Act, 716(c)(8) of ERISA, 9816(c)(8) of IRC)

Nature of IDR process

Under the Act, the IDR process allows a nonparticipating provider, a nonparticipating emergency facility, nonparticipating air ambulance provider, or health plan to request that a payment be increased or decreased. If a settlement is not reached with respect to that request, the IDR entity must determine in accordance with the Act’s requirements an alternative payment amount. (new sec. 4(a)(1) of the bill)

Authority to continue negotiation. If the parties to a determination agree on a payment amount to the nonparticipating provider or facility during the IDR process but before the date on which the selected IDR entity makes a determination, that payment amount is the amount agreed to by the parties. The IDR process must then provide for a method to determine how to allocate between the parties the payment of the compensation of the selected IDR entity. (new secs. 2799A-1(c)(2)(B) and (C) of the PHS Act, 716(c)(2)(B) and (C) of ERISA, and 9816(c)(2)(B) and (C) of IRC)

Treatment of batching items and services. The Secretary is required to specify criteria under which multiple qualified IDR dispute items and services are permitted to be considered jointly as part of a single determination by an entity for

purposes of encouraging efficiency (including minimizing costs) of the IDR process. Such items and services may be so considered only if: (i) they are furnished by the same provider or facility; (ii) payment for such items and services is required to be made by the same health plan; (iii) such items and services are related to the treatment of a similar condition; and (iv) the items and services were furnished during the 30-day period following the date on which the first item or service included with respect to the determination was furnished (or an alternative period as determined by the Secretary, for use in limited situations to encourage procedural efficiency and minimize health plan and provider administrative costs). (new secs. 2799A-1(c)(3) of PHS Act, 716(c)(3) of ERISA and 9816(c)(3) of the IRC)

Treatment of bundled payments. The Secretary is required to permit that, in the case of items and services which are included by a provider or facility as part of a bundled payment, they be part of a single determination. (new secs. 2799A-1(c)(3)(B) of PHS Act, 716(c)(3)(B) of ERISA, 9816(c)(3)(B) of IRC)

Submission of offers and information. Not later than 10 days after the date of selection of the IDR entity, the provider or facility and the health plan that is a party to the determination must submit to the IDR entity an offer for a payment amount and such information as requested by the IDR entity relating to the offer and may each submit to the IDR entity with respect to the determination any information relating to such offer submitted by either party, including information relating to any certain specified circumstances. (see “*Factors to be used in determining IDR outcome*” below). (new secs. 2799A-1(c)(5)(B) of the PHS Act, 716(c)(5)(B) of ERISA, 9816(c)(5)(B) of IRC)

Payment Determination. Not later than 30 days after the date of selection of the IDR entity, the selected entity (taking into account only the considerations listed below) must select one of the offers submitted by the parties as the payment amount and notify the provider or facility and the health plan of the offer selected. (new secs. 2799A-1(c)(5)(A) of the PHS Act, 716(c)(5)(A) of ERISA, 9816(c)(5)(A) of IRC)

Factors to be used in determining IDR outcome for services other than air ambulance services

The Act calls for the IDR entity to consider: (i) the offers submitted by the parties; (ii) the qualifying payment amounts for the applicable year for the items or services that are comparable to the qualified IDR item or service and that are furnished in the same geographic region (as defined by the Secretary) as the qualified IDR item or service; and (iii) information on any circumstance described below, and any requested or additional related information (see “*Nature of IDR process*” above). (new secs. 2799A-1(c)(5)(C) of the PHS Act, 716(c)(5)(C) of ERISA, 9816(c)(5)(C) of IRC)

In addition, the IDR entity is required to consider information submitted by the parties on the: (i) level of training, experience, and quality and outcomes measurements of the provider or facility (such as those endorsed by the consensus-based entity authorized under section 1890 of the SSA); (ii) the market share held by the nonparticipating provider or facility, or the health plan, in the geographic area in which the item or service was provided; (iii) the acuity of the individual receiving the item or service or the complexity of furnishing the item or service to that individual; (iv) the teaching status, case mix, and scope of services of the nonparticipating facility that furnished the item or service; and (v) demonstrations of good faith efforts (or lack of good faith efforts) made by the nonparticipating provider or nonparticipating facility or the health plan to enter into network agreements and, if applicable, contracted rates between the provider and facility and the health plan during the previous 4 years. (new secs. 2799A-1(c)(5)(C) of the PHS Act, 716(c)(5)(C) of ERISA, 9816(c)(5)(C) of IRC)

The IDR entity is prohibited from considering the usual and customary charges, the amount that would have been billed by the provider or facility (i.e., the billed charges) had the balance billing prohibitions of this legislation not applied, or the payment or reimbursement rate for such items and services furnished by the provider or facility payable by a public payer, include under Medicare, Medicaid, CHIP, TRICARE, or the VA. (new secs. 2799A-1(c)(5)(D) of the PHS Act, 716(c)(5)(D) of ERISA, 9816(c)(5)(D) of IRC; also new secs. 2799A-2(b)(5)(C)(iii) of the PHS Act, 717(b)(5)(C)(iii) of ERISA, 9817(b)(5)(C)(iii) of IRC)

Factors to be used in determining IDR outcome for services for air ambulance services

In cases involving air ambulance services, the IDR entity must consider factors in the same manner as for other services (above), including information submitted by the parties on the: (i) the quality and outcomes measurements of the provider that furnished the services; (ii) the acuity of the individual receiving the item or service or the complexity of furnishing the service to that individual; (iii) the training, experience, and quality of the medical personnel that furnished the services; (iv) the ambulance vehicle type, including the clinical capability of the vehicle; (v) the population density of the pick-up location (e.g., urban, suburban, rural or frontier); (vi) demonstrations of good faith efforts (or lack of good faith efforts) made by the provider or health plan to enter into network agreements and, if applicable, contracted rates between the provider and the health plan during the previous 4 years. (new secs. 2799A-2(b)(5)(C) of the PHS Act, 717(b)(5)(C) of ERISA, 9817(b)(5)(C) of IRC)

IDR determinations are binding

The IDR's determination is binding upon the parties involved in the absence of a fraudulent claim or evidence of misrepresentation of facts presented to the IDR entity regarding such claim. Moreover, the determination is not subject to judicial review except in cases described in certain paragraphs of title 10(a) of title 9 of the USC. This section of title 9 refers to cases--(1) where the award was procured by corruption, fraud, or undue means; (2) where there was evident partiality or corruption in the arbitrators; (3) where the arbitrators were guilty of misconduct in refusing to postpone the hearing or in refusing to hear evidence pertinent and material to the controversy; or of any other misbehavior by which the rights of any party have been prejudiced; or (4) where the arbitrators exceeded or imperfectly executed their powers. (new secs. 2799A-1(5)(E) of the PHS Act, of the PHS Act, 717(b)(5)(E) of ERISA, 9817(b)(5)(E) of IRC)

Limits certain subsequent IDR claims

The Act prohibits the initiating party from submitting a request for IDR for the same item with respect to the same party during the 90-day period following the IDR determination. The Act permits a subsequent request for IDR relating to all claims that occur during that 90-day suspension period to be eligible for IDR upon completion of that 90-day period.

Report. The Secretaries of Labor and Treasury are required to examine the impact of the application of the subsequent submission provision described above and whether that delays payment determinations or impacts early, alternative resolution of claims (such as through open negotiations) and submit an interim report to Congress, not later than 2 years after the date of implementation and, not later than 4 years after implementation, a final report, on whether any health plans or types of such plans have a pattern or practice of routine denial, low payment, or down-coding of claims, or otherwise abuse the 90-day suspension of IDR period, including recommendations on ways to discourage such a pattern or practice. (new secs. 2799A-1(c)(5)(E) of the PHS Act, 716(c)(5)(E) of ERISA, 9816(c)(5)(E) of IRC)

Timing of payment

The Act requires health plans to pay directly to the nonparticipating provider or facility any amount (as determined under open negotiations or by the IDR entity) within 30 days of the date of the determination. (new secs. 2799A-1(c)(6) of the PHS Act, 716(c)(6) of ERISA, 9816(c)(6) of IRC)

Public disclosure

Publication of information relating to the IDR process for services other than air ambulances. Beginning for each calendar quarter in 2022 and each quarter thereafter, the Secretary must make available on a public HHS website for the quarter: (i) the number of IDR notifications; (ii) the size of the provider practices and facilities submitting IDR notifications; (iii) the number of such notifications with respect to which an IDR payment determination was made; (iv) the information with respect to which a determination was made; (v) the number of times the payment amount determined (or agreed to) exceeded the qualifying payment amount, specified by items and services; (vi) the amount of

expenditures by the Secretary to carry out the IDR process; (vii) the total amount of fees paid; and (viii) the total amount of compensation paid to certified IDR entities.

The information to be reported must include a description of each item and service in the notification; (ii) the geography in which the items and services covered by the notification were provided; (iii) the amount of the offer submitted by the health plan and by the nonparticipating provider or facility expressed as a percentage of the qualifying payment amount; (iv) whether the offer selected by the IDR entity to be the payment was the offer submitted by the health plan or provider or facility and the amount of the offer selected expressed as a percentage of the qualifying payment amount; (v) the category and practice specialty of the provider or facility; (vi) the identity of the health plan, provider or facility; (vii) the length of time in making each determination; (viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and (ix) any other information specified by the Secretary.

Publication of information relating to the IDR process for air ambulance services. Beginning for each calendar quarter in 2022 and each quarter thereafter, the Secretary must make available on a public HHS website for the quarter: (i) the number of IDR notifications; (ii) the number of such notifications with respect to which an IDR payment determination was made; (iii) the information described below (with respect to each notification of a determination); (iv) the number of times the payment amount determined (or agreed to) exceeded the qualifying payment amount; (v) the total amount of fees paid; and (viii) the total amount of compensation paid to certified IDR entities. Requires the reported information to include: (i) a description of each air ambulance service included in the notification; (ii) the geography in which the items and services covered by the notification were provided; (iii) the amount of the offer submitted by the health plan and by the nonparticipating provider expressed as a percentage of the qualifying payment amount; (iv) whether the offer selected by the IDR entity to be the payment was the offer submitted by the health plan or provider and the amount of the offer selected expressed as a percentage of the qualifying payment amount; (v) the ambulance vehicle type, including the clinical capability level of the vehicle; (vi) the identity of the health plan or air ambulance provider; (vii) the length of time in making each determination; (viii) the compensation paid to the certified IDR entity with respect to the settlement or determination; and (ix) any other information specified by the Secretary. (new secs. 2799A-2(b)(7)(B), (C) and (D) of the PHS Act, 717(b)(7)(B), (C) and (D) of ERISA, 9817(b)(7)(B), (C) and (D) of IRC)

IDR entity requirements. Beginning for 2022 and each subsequent year, an IDR entity as a condition of certification, is required to submit to the Secretary such information as the Secretary determines necessary to carry out the information provisions as specified above.

Clarification. The Secretary is required to ensure the above public reporting does not contain information that would disclose privileged or confidential information of a health plan or of a provider or facility. (new secs. 2799A-1(c)(7) of the PHS Act; 716(c)(7) of ERISA, 9816(c) of IRC)

Patient-Provider Dispute Resolution Process

The Act requires the Secretary, not later than January 1, 2022, to establish a patient-provider dispute resolution process. Under this process, an uninsured individual who received a good faith advance estimate from a provider or facility (see “*Advanced Explanation of Benefits*” below) of their expected charges (under new sec. 2799B-6 of the PHS Act as added by this Act) and who then receives a bill from that provider or facility for charges that are substantially in excess of the estimate, to seek a determination from a selected dispute resolution entity for the charges to be paid by the individual. “Uninsured individual” is one without benefits for the item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, Federal health care program (as defined in section 1128B(f) of the SSA) or FEHBP (or an individual who has benefits under one of those sources of coverage but who does not seek to have a claim for such item or service submitted to it).

Selection of entities. The Secretary is required to provide for a method to select that a dispute resolution entity to make the determination: (i) is not a party to the determination or an employee or agent of such party; (ii) does not have a

material familial, financial, or professional relationship with such a party; and (iii) does not otherwise have a conflict of interest with such a party (as determined by the Secretary). The Secretary must provide for a notification of the selection to the individual and the applicable provider or facility.

Administrative fee. The Secretary is required to establish a fee to participate in this patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to the process.

Certification. The Secretary is also required to establish or recognize a process to certify entities that ensures that an entity at least satisfy the certification criteria for independent dispute resolution entities (see "*Certification of IDR Entities*" above) (new sec. 2799B-7 of the PHS Act)

Additional Disclosure Requirements

Requirements on health plans to disclose balance billing prohibitions and network and cost-sharing information to enrollees

Health Plan Website. Each health plan is required to make publicly available, post on its website, and include on each an explanation of benefits for an item or service with respect to which the No Surprises Act's balance billing prohibitions apply: (1) information in plain language on: (a) the prohibitions on balance billing; (b) if provided for under applicable State law, any other requirements regarding the amounts the providers and facilities may charge an enrollee if the provider or facility does not have a contractual relationship under the health plan after receiving payment from the health plan and any applicable cost-sharing payment; and (c) the Act's protections against surprise billing with respect to the furnishing of emergency and non-emergency services; and (2) information on contacting appropriate State and federal agencies in the case that an individual believes that the provider or facility has violated any related requirement. (new secs. 2799A-5(c) of the PHS Act, 720(c) of ERISA and 9820(c) of IRC)

A health plan will also be required to include, in clear writing, on the physical or electronic plan or insurance identification card issued to enrollees: (i) any deductible applicable to the health plan; (ii) any out-of-pocket maximums; and (iii) a telephone number and website through which the individual may seek consumer assistance information, such as information related to hospitals and urgent care facilities that have in effect a contractual relationship with the health plan. (new secs. 2799A-1(e) of the PHS Act, 716(b) of ERISA, and 9816(e) of the IRC)

Advanced Explanation of Benefits. Each health plan that has received a notification from a provider or facility of a scheduled item or service for an individual is required to provide to that individual (or their authorized representative) within certain time frames (see below) (through mail or electronic means, as requested by the person) a notification in clear and understandable language that includes: (1) Whether or not the provider or facility is participating with respect to the health plan for the item or service and, if participating, the contracted rate or coverage (based on the billing and diagnostic codes provided by the provider or facility) and if it is nonparticipating, then a description of how the individual may obtain information on providers and facilities that are participating. (2) The good faith estimate included in the notification received from the provider or facility based on such codes. (3) A good faith estimate of the amount the plan is responsible for and the amount of any enrollee cost sharing (including with respect to the deductible and any copayment or coinsurance obligation (as of the date of the notification). (4) A good faith estimate of the amount that the enrollee has incurred toward meeting the limit of the financial responsibility (including with respect to deductibles and out-of-pocket maximums) under the plan (as of the date of such notification). (5) If the item or service is subject to a medical management technique (including concurrent review, prior authorization, and step-therapy or fail-first protocols) for coverage, a disclaimer that the coverage is subject to that medical management technique. (6) A disclaimer that the information provided in the notification is only an estimate based on the items and services reasonably expected, at the time of scheduling (or requesting) the item or service, to be furnished and is subject to change. (7) A statement that the individual may seek the item or service from a participating provider or a facility and a list of those, as applicable, who are able to furnish the items and services involved. (8) Any other information or

disclaimer the plan determines appropriate that is consistent with information and disclaimers required under this section of the Act.

Time frames. Under the act, the above notice must be provided not later than 1 business day after the provider or facility gives notice to the health plan or, if the item or service was scheduled in time, then at least 10 business days before the item or service is to be furnished. If the notification was made pursuant to an enrollee request, then the time is 3 business days after the date on which the plan receives the notification. The Secretary may modify these timing requirements in the case of specified items and services, but any modification made by the Secretary may not result in the provision of the notification after the person has been furnished the items or services. (new secs. 2799A-1(f) of the PHS Act, 9816(f)716(f) of ERISA of IRC and 716(f) of ERISA)

Requirements on providers to disclose cost sharing/ balance billing to their patients enrolled in health plans

Provision of information upon request and for scheduled appointments. Beginning January 1, 2022, in the case of an individual who schedules an item or service, the provider and facility are required to provide to that individual certain information within certain timeframes: (1) inquire if the individual is enrolled in a health plan or a federal health care program (and if so enrolled in the health plan, seeking to have a claim for the item or service submitted to the health plan); and (2) provide a notification (in clear and understandable language) of the good faith estimate of the expected charges for the item or service (including any item or service reasonably expected to be provided in conjunction with the scheduled item or service and that item or service is reasonably expected to be provided by another provider or facility), with the expected billing and diagnostic codes for the item or service to: (i) in the case that the individual is enrolled in the health plan (and is seeking to have a claim submitted to the health plan); and (ii) if the individual is not in a health plan or enrolled in a federal health care program (and not seeking to have the claim submitted to the health plan), then the notification should be to the individual. The above notice is to be provided: at least 3 business days before the date the item or service is to be furnished; not later than 1 business day after scheduling (or, in the case of an item or service scheduled at least 10 business days before the date of the service or item (or if requested by the individual), not later than 3 business days after the date of such scheduling or such request). (new sec. 2799B-6 of the PHS Act)

Provider Directories and Price Comparison Tools

Requirements on providers and facilities

Beginning not later than January 1, 2022, each provider and facility is required under the Act to have in place business processes to ensure the timely provision of provider directory information to a health plan to support the provider directory requirements under the No Surprises Act (as described below) when beginning a network agreement with a health plan; when the provider or facility terminates a network agreement; when there are any material changes to the provider directory information; and at any other time (including at the request of the health plan) determined appropriate by the provider, facility, or the Secretary. (new sec. 2799B-9 of the PHS Act)

Refunds to enrollees. If a provider submits a bill to an enrollee based on cost sharing for treatment or services furnished by the provider in excess of in-network cost sharing (as defined under the Act) and the enrollee pays the bill, the provider must reimburse the enrollee for the full amount in excess of the in-network cost sharing amount, plus interest, at a rate determined by the Secretary. This provision does not, however, prohibit a provider from requiring in the terms of a contract or contract termination with a health plan that the plan remove, at the time of contract termination, the provider from the directory or that the plan bear the financial responsibility for providing inaccurate network status information to an enrollee.

These provisions do not preempt any provision of State law relating to provider directories. (new sec. 2799B-9 of the PHS Act)

No Surprises Act (H.R. 133, Public Law 116-260) — Summary

In addition, each provider and facility is required to make publicly available and, if applicable, post on its public website and provide to individuals who are enrollees of a health plan a one-page notice (either postal or electronic, as specified by the person) in clear and understandable language containing information: (1) on requirements and prohibitions on balance billing in certain circumstances (specified by the Act); (2) if required under State law, any other requirements on the provider or facility regarding the amounts it may charge an enrollee with respect to an item or service to which the provider or facility may balance bill if it is nonparticipating with the health plan; and (3) information on contacting appropriate State and federal agencies in the case that an individual believes that the provider or facility has violated the Act's balance billing prohibitions. (new sec. 2799B-3 of the PHS Act)

A nonparticipating provider or nonparticipating facility is prohibited from imposing on any enrollee a cost-sharing amount for an item or service covered by a health plan that is greater than the cost sharing that would apply or applying a deductible or OOP maximum that is different than would apply if the services were furnished by a participating provider or facility if the individual received inaccurate information about the participation status of the provider (as specified under the Act). (new secs. 2799A-5(b) of the PHS Act, 720(b) of ERISA, 9820(b) of IRC)

Requirements on health plans

Each health plan must establish: (i) a verification process; (ii) a response protocol; and (iii) a provider database and include in any directory (other than the database) specified provider directory information. Under the verification process, the health plan—not less frequently than once every 90 days—must verify and update the provider directory information in a database. It must establish a procedure for the removal from the database of a provider or facility if the plan has been unable to verify the information during a period specified by the health plan. The database must be updated within 2 business days of the health plan receiving information that a provider or facility has changed its network status (as required under new sec. 2799B-9 of the PHS Act).

Response protocol. In the case of an individual enrolled in a health plan who requests information through a telephone call, electronic web-based means, or email on whether a provider or facility has a contractual relationship, the health plan must have a protocol that responds to the individual as soon as practicable and in no case later than 1 business day after the call or email is received, through a written electronic or paper (as requested by the individual) communication. This communication must be retained in the individual's file for at least 2 years thereafter.

The Act also requires the health plan to maintain on its public website a list of each provider and facility with which it has a direct or indirect contractual relationship and provider directory information with respect to each such provider and facility. The information must be accurate as of the date of the provider directory publication and indicate that the individual should consult the database to obtain the most current information. The information must include the name, address, specialty, and telephone number of each provider or facility with which the health plan has a contractual relationship for furnishing items and services under the specific health plan. (new secs. 2799A-5(a) of the PHS Act, 720 of ERISA and 9820 of the IRC).

This section of the Act states that nothing in it shall be construed to preempt State law relating to health care provider directories. (new sec. 2799A-5(a)(7) of the PHS Act). (Note that under new sec. 720(a)(7) of ERISA, the provider directory requirements do not preempt State law to the extent that the law applies to state-regulated insurance.)

Price comparison tool. The Act requires a health plan to offer price comparison guidance by telephone and make available on its website a price comparison tool that (to the extent practicable) allows an enrollee, for the plan year, geographic region, and its participating providers, to compare the amount of cost sharing that the enrollee would be responsible for paying with respect to the furnishing of a specific item or service by any such provider. (new secs. 2799A-4 of the PHS Act, 9810 of IRC, and 719 of ERISA)

Continuity of Care Requirements

Continuity of care requirements on health plans and issuers

Continuity of care when contract terminations affect provider network status. Under the No Surprises Act, if an individual with benefits under a health plan with respect to an in-network provider or facility is a continuing care patient (see the below paragraph) with that provider or facility and: (1) the contractual relationship with the plan is terminated (defined as including, “with respect to a contract, the expiration or nonrenewal of a contract, but does not include a termination of the contract for failure to meet applicable quality standards or for fraud”); (2) benefits are terminated because of a change in the terms of the participation of the provider or facility; or (3) the health plan contract is terminated resulting in the loss of benefits with respect to the provider or facility, then the health plan must: (1) notify each enrollee who is a continuing care patient on a timely basis of the termination and their right to elect continued transitional care from the provider or facility; (2) provide the individual with an opportunity to notify the health plan of the individual’s need for transitional care; and (3) permit the individual to elect to continue to have their benefits for the course of treatment relating to the individual’s status as a continuing care patient during the period beginning on the date on which the above notice is provided and ending on the earlier of (i) the 90-day period beginning on such date; or the (ii) date on which such individual is no longer a continuing care patient with respect to their provider or facility. (new secs. 2799A-3 of the PHS Act; 9818 of the IRC; 718 of ERISA)

Continuing care patient. Such patient is an individual who, with respect to a provider or facility, is (i) undergoing a treatment for a “serious and complex condition” from that provider or facility; (ii) is undergoing a course of institutional or inpatient care from it; (iii) is scheduled to undergo nonelective surgery from the provider, including postoperative care; (iv) is pregnant and undergoing a course of treatment for the pregnancy; or (v) is or was determined to be terminally ill (as determined under the Medicare hospice benefit and is receiving treatment for such illness. (new secs. 2799A-3 of the PHS Act; 9818 of the IRC; 718 of ERISA) A “serious and complex condition” is defined, in the case of an acute illness, as 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 is life-threatening, degenerative, potentially disabling, or congenital; and requires specialized medical care over a prolonged period of time. (new secs. 2730(b)(2) of the PHS Act; 9817(b) of the IRC; 717(b) of ERISA)

Continuity of care requirements on providers and facilities

Under the Act, in the case of an individual who meets the above definition of a continuing care patient and who has a health plan that includes coverage of continuity of care, the provider or facility must: (1) accept payment from the plan and any applicable cost sharing from the individual as payment in full and (2) continue to adhere to all policies, procedures, and quality standards imposed by the plan in the same manner as if termination had not occurred. (new sec. 2799B-8 of the PHS Act)

Enforcement

In general

The No Surprises Act incorporates the underlying enforcement framework of the PHS Act, thus providing that States are relied on to enforce the new Act’s federal hold harmless protections, payment rules, IDR process, provider directory and other information, and transparency requirements on State-regulated health insurance issuers of group and individual health insurance coverage. Note that State-regulated plans include state and local governmental plans. If the Secretary determines that a State has failed to substantially enforce the federal provisions with respect to those issuers/coverage, then the Secretary shall enforce them. See sec. 2724 of the PHS Act (42 USC 300gg-23). This is executed through conforming amendments through which “Part D—Additional Coverage Provisions” are included under section 2724 of the PHS Act. (sec. 102(3)(D) of the Act)

Enforcement standards for facilities and providers

State enforcement. As stated above, each State may enforce the Act's federal prohibition on surprise billing (OON cost sharing and balance billing) and the other provisions in the new Part D of Title XXVII of the PHS Act that are added by the Act (e.g., the IDR process). The Act further provides that if the Secretary determines that a State has failed to substantially enforce those requirements, the Secretary shall enforce them. A State may notify the Secretary of Labor, HHS or Secretary, as applicable, of instances of violations of the provisions of the Act relating to its balance billing prohibitions in cases of emergency, non-emergency, and ambulance services with respect to enrollees under a health plan and any enforcement actions taken against providers or facilities as a result of such violations, including the disposition of any such enforcement actions. (new secs. 2799B-4(a) and (B) of the PHS Act)

Secretarial Enforcement Authority. The Act authorizes the Secretary to impose a CMP in an amount not to exceed \$10,000 per violation. This CMP authority is limited to enforcement of provisions where a State has failed to enforce the Act's requirements.

The Secretary is required through rulemaking, in consultation with the Secretary of Labor, to establish a process to receive consumer complaints of violations and resolve those complaints within 60 days of their receipt. (new secs. 2799B-4(b)(1) and (2) of the PHS Act)

Exception. The Secretary may waive CMP penalties with respect to a facility or practitioner (including an air ambulance provider) who does not knowingly violate, and should not have reasonably known it violated, the Act's balance billing prohibitions, if the facility or provider, within 30 days of the violation, withdraws the balance bill and reimburses the health plan or enrollee, as applicable, in an amount equal to the difference between the amount billed and the allowable amount to be billed under the provision, plus interest (at an interest rate determined by the Secretary). The Secretary may establish a hardship exemption to the penalties. (new secs. 2799B-4(b)(4) and (5) of the PHS Act)

Continued Applicability of State law. The Act provides that State law applies unless it prevents the application of the Act's requirements or prohibitions related to surprise bills, balance billing, the determination of rates and IDR process, transparency regarding in-network and OON cost sharing, the provision of an advanced explanation of benefits, continuity of care, etc. (new sec. 2799B-4(c) of the PHS Act)

Coordination of enforcement with Department of Labor regarding violations. The Act requires the Secretary of Labor, upon receiving a notice from a State or from the Secretary of HHS of violations of the bill's balance billing provisions (including those relating to air ambulance services), to investigate (pursuant to section 504 of ERISA) so as to identify patterns of violations and to coordinate with States and the Secretary of HHS, in accordance with the coordination of enforcement provisions of ERISA (section 506) and HIPAA (section 104), where appropriate, as determined by the Secretary, to ensure that appropriate measures have been taken to correct the violations retrospectively and prospectively. (new sec. 522(a) of ERISA)

Complaint process. The Act also requires the Secretary of Labor to ensure a process under which that Secretary may receive complaints from enrollees of group health plans or group coverage offered by a health plan relating to alleged balance billing violations (see above) and transmits such complaints to the States or the Secretary of HHS (as determined appropriate by the Secretary of Labor) for potential enforcement actions. (new sec. 522(b) of ERISA)

Enforcement standards for group health plans and health insurance issuers

See above related to IDR provisions.

The Act does not include a specific provision but the underlying provisions of the PHS Act provide for enforcement by the States of the Act's various requirements described above of state-regulated health insurance and the issuers of that

insurance, and by the federal government in those cases where a State has failed to enforce or in the case of group health plans that are not subject to State regulation because of ERISA preemption.

All Payer Claims Databases

The Act requires the Secretary to make one-time grants to eligible States to: (1) establish a State All Payer Claims Database (APCD) and (2) to improve an existing State APCD. To be eligible for a grant, a State must submit to the Secretary an application that includes information on how the State will ensure uniform data collection and the privacy and security of the database. The APCD may include medical claims, pharmacy claims, dental claims and eligibility and provider files, which are collected from private and public payers. (new secs. 320B-(a), (b), (c) and (g) of the PHC Act as added by sec. 115 of the bill)

Entities desiring authorization for access to an APCD supported by a grant must submit an application, which must include a description of the uses and methodologies for evaluating health system performance using such data and documentation of approval by an institutional review board, if applicable. For entities such as an employer, health insurance issuer, third-party administrator or health care provider requesting access for the purpose of quality improvement or cost containment, applications must include a description of the intended uses for the data. The Secretary may prioritize applications from States whose application demonstrates a willingness to work with other States to establish a single application for access to data by authorized users across multiple States. The Secretary may also prioritize applications submitted by a State whose application demonstrates that the State will implement the reporting format for self-insured group health plans. (new sec. 320B(e) of the PHS Act as added by sec. 115 of the bill)

Standardized Report Format. The Act requires the Secretary of Labor, not later than one year after enactment, to establish a standardized format for reporting by self-insured group health plans to State APCDs of medical claims, pharmacy claims, dental claims and eligibility and provider files, and provide guidance to States on the process for collecting such data in the standardized reporting format. Not later than 90 days after enactment, the Secretary must convene an Advisory Committee of 15 members to advise regarding the format and guidance. The Act specifies the process for appointing members to the Committee and provides for staggered 3-year terms. It requires the Committee to report to the Secretary, Senate Committee on HELP and the House Committees on Energy and Commerce and Education and Labor with recommendations on the establishment of the format and guidance described above. The Act authorizes and appropriates \$5 million for fiscal year 2021 to carry out these Department of Labor provisions and sunsets this section on the date the above report is submitted. (new sec. 735 of ERISA as added by sec. 115 of the bill)

The Act authorizes and appropriates \$50 million for each of fiscal years 2022 and 2023 and \$25 million for fiscal year 2024 to remain available until expended (new sec. 320B(h) of the PHS Act as added by sec. 115 of the bill). It provides that the grants awarded be for a period of three years and in an amount of \$2.5 million of which \$1 million is made available to the State for each of the first two years of the grant period and \$500,000 be made available to the State for the third year of the grant period. (new sec. 320B(d) of the PHS Act as added by sec. 115 of the bill)

Additional Required Federal Agency Reports and Studies

Secretarial Reports. The Act requires by January 2, 2023, and annually thereafter, that the Secretary of HHS, in consultation with the Federal Trade Commission and the Attorney General, conduct a study on the effects of the above described provisions on: (1) any patterns of vertical or horizontal integration of health care facilities, providers, health plans, (2) overall health care costs; (3) access to services, including specialty services, in rural areas and health professional shortage areas; and (4) recommendations, made in consultation with the Secretaries of Labor and Treasury for effective enforcement of provisions of the Act (relating to preventing surprise bills), including potential challenges to addressing anti-competitive consolidation by health care facilities, providers, and health plans. The Secretary is required

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to report on this study to the Senate HELP; Commerce, Science and Transportation; Finance; and Judiciary and House Education and Labor, Energy and Commerce; Ways and Means; and Judiciary Committees. (sec. 109 of the bill)

GAO Report on Impact of Surprise Billing. By not later than January 1, 2025, the Government Accountability Office (GAO) is required to submit to Congress a report summarizing the effects of the No Surprises Act, including any amendments, on changes since its enactment in provider networks, fee schedules and amounts for health care services, and to contracted rates. The Act specifies the required scope and subjects to be covered in the report. (sec. 109(b) of the bill)

GAO Report on Adequacy of Provider Networks. By not later than January 1, 2023, GAO is required to submit to Congress, and make publicly available, a report on the adequacy of provider networks in group health plans and group and individual coverage, including legislative recommendations to improve network adequacy. (sec. 109(c) of the bill)

GAO Report on IDR Process and Potential Financial Relationships. By not later than January 1, 2023, GAO is required to submit to Congress a report on the IDR process established under this legislation. The study and report must include an analysis of potential financial relationships between providers and facilities that use the IDR process and private equity investment firms. (sec. 1109(d) of the bill)

Glossary of Definitions (not incorporated elsewhere) and Acronyms

Definitions

Air ambulance service. Medical transport by helicopter or airplane for patients. (new secs. 2799B-2(c) of the PHS Act, 717(c) of ERISA and 9817(c) of IRC)

Conditions for coverage of additional services. These include: (1) the provider or facility determines the individual, once stabilized, is able to travel using nonmedical transportation or non-emergency medical transportation; (2) the provider furnishing additional items and services satisfies the notice and consent criteria (see “*Notice and consent requirement exception*” above); (3) the individual is in a condition to receive (as determined in accordance with guidelines issued by the Secretary pursuant to rulemaking) the consent-related information and to provide informed consent, in accordance with applicable State law; and (4) such other conditions are met that are specified by the Secretary relating to coordinating care transitions to participating facilities and providers. (new secs. 2799A-1(a)(3)(C) of the PHS Act; 716(a)(3)(C) of ERISA and 9816(a)(3)(C) of IRC)

Cost sharing. Copayment, coinsurance and deductibles. (secs. 2799A-1(a)(3)(L) of the PHS Act, 716(a)(3)(L) of ERISA, 9816(a)(3)(L) of the IRC)

Emergency department of a hospital. Includes a hospital outpatient department that provides emergency services. (new secs. 2799A-1(a)(3)(A) of the PHS Act, 716(a)(3)(A) of ERISA and 9816(a)(3)(A) of IRC)

Emergency medical condition. A medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine could reasonably expect the absence of immediate medical attention to result in a condition described in the EMTALA provisions of the SSA. (new secs. 2799A-1(a)(3)(B) of the PHS Act; 716(a)(3)(B) of ERISA and 9816(a)(3)(B) of IRC)

Emergency services. With respect to an emergency medical condition, a medical screening examination within the capability of the emergency department of a hospital or of an independent freestanding emergency department, including ancillary services routinely available to the emergency department to evaluate such emergency medical condition; and within the capabilities of the staff and facilities available at the hospital or the independent freestanding emergency department, such further medical examination and treatment to stabilize the individual regardless of the department of the hospital in which the further examination or treatment is furnished. Emergency services also include those post-stabilization¹ services as part of outpatient observation or an inpatient or outpatient stay during a visit if the items and services would otherwise be covered under the plan if furnished by a participating provider or facility unless certain conditions with respect to the participant, beneficiary or enrollee exist. (new secs. 2799A-1(a)(3) (C) of the PHS Act, 716(a)(3)(C) of ERISA and 9816(a)(3)(C) of IRC)

Enrollee. Under the PHS Act amendments in the Act, a person who is a member of a health plan or insurance coverage subject to the surprise billing protections of the Act may be a participant, beneficiary or an enrollee. Under the ERISA provisions, the Act applies to participants and beneficiaries of a group health plan or group coverage offered by a health insurance issuer. Under the IRC provisions, the Act applies to participants and beneficiaries in group health plans.

Independent freestanding emergency department. A facility that is geographically separate and distinct and licensed separately from a hospital under State law and provides emergency services.

Medical screening examination. An examination required under the EMTALA provisions of the SSA (section 1867).

¹ “To stabilize” has the meaning given in section 1867(e)(3)(A) of the SSA.

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Nonparticipating emergency facility. With respect to an item or service and a group health plan or group or individual coverage offered by an issuer, an emergency department of a hospital, or an independent freestanding emergency department, that does not have a contractual relationship directly or indirectly with the plan or issuer, respectively, for furnishing the item or service at the facility. (new secs. 2799A-1(a)(3)(F) of the PHS Act; 716(a)(3)(F) of ERISA, and 9816(a)(3)(F) of the IRC)

Nonparticipating facility. (1) With respect to emergency services, an emergency department of a hospital or an independent freestanding emergency department that does not have a contractual relationship with the health plan with respect to furnishing services under the health plan, and (2) with respect to post-stabilization services, a hospital or an independent free-standing emergency department that does not have a contractual relationship with the health plan with respect to furnishing services under the health plan.

Nonparticipating provider. With respect to an item or service and a group health plan or group or individual coverage offered by an issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification of State law and who does not have a contractual relationship with the plan or issuer, respectively, for furnishing the item or service under the health plan. (new secs. 2799A-1(a)(3)(G)(ii) of the PHS Act; 716(a)(3)(G) of ERISA, 9816(a)(3)(G) of IRC)

Outpatient observation services. Observation services are hospital outpatient services that are provided while a doctor decides whether to admit a person as an inpatient or discharge the person. Observation services may be provided in the emergency department or another area of the hospital.

Participating emergency facility. With respect to an item or service and a group health plan or group or individual coverage offered by an issuer, an emergency department of a hospital, or an independent freestanding emergency department, that has a contractual relationship directly or indirectly with the plan or issuer, respectively, with respect to furnishing an item or service at the facility. (new secs. 2799A-1(a)(3)(F) of the PHS Act; 716(a)(3)(F) of ERISA, 9816(a)(3)(F) of IRC)

Participating facility. (1) With respect to emergency services that are not post-stabilization services, an emergency department of a hospital or an independent freestanding emergency department that has a contractual relationship with the health plan with respect to furnishing services under the health plan and (2) with respect to emergency services (including post-stabilization services), a hospital or an independent free standing emergency department that has a contractual relationship with the plan or the issuer with respect to furnishing of services under the health plan. (new sec. 2799B-2(f) of the PHS Act)

Participating provider. With respect to an item or service and a group health plan or group or individual health insurance coverage offered by a health insurance issuer, a physician or other health care provider who is acting within the scope of practice of that provider's license or certification of State law and who has a contractual relationship with the plan or issuer, respectively, for furnishing the item or service under the health plan. (new secs. 2799A-1(a)(3)(G)(ii) of the PHS Act; 716(a)(3)(G) of ERISA, 9816(a)(3)(G) of IRC)

Visit. With respect to items and services furnished to an individual at a health care facility, including equipment and devices, telemedicine services, imaging services, laboratory services, postoperative services and such other items and services as the Secretary may specify, regardless of whether or not the provider furnishing such items or services is at the facility. (new 2799A-1(b)(2)(B) of the PHS Act, 716(b)(2)(B) of ERISA and 9816(b)(2)(B) of IRC)

Acronyms

APCD — All Payer Claims Database

CHIP — Children’s Health Insurance Program

CMP — Civil monetary penalty

CPI-U — Consumer Price Index for All Urban Consumers

ERISA — Employee Retirement Income Security Act

FEHBP — Federal Employees Health Benefits Program

GAO — Government Accountability Office

HELP — Senate Committee on Health, Education, Labor, and Pensions

HHS — U.S. Department of Health and Human Services

IDR — Independent Dispute Resolution

OON — Out of network

OOP — Out of pocket

PHS Act — Public Health Service Act

SSA — Social Security Act