STRATEGIC HEALTH CARE

January 5, 2021

# Summary of Surprise Billing Law

An agreement on surprise billing language was included in the year-end spending/COVID-19 relief package, HR 133. Click here for the bill – the surprise billing section begins on page 1628. Click here for the Congressional Summary of the No Surprises Act. The legislation was signed into law on December 27, 2019.

The measure would generally limit surprise billing in the following circumstances:

- Out-of-network emergency services, including services furnished after a patient is stabilized unless notice and consent criteria are met.
- Ancillary services, such as anesthesiology, radiology, and laboratory services, from an out-of-network provider.
- Other services provided by an out-of-network provider at an in-network facility, unless notice and consent criteria are met.
- In these scenarios, the patient's cost-sharing responsibility would be the same as the in-network amount and would be calculated based on the plan's median in-network rates for similar services in the same geographic region. That calculation would apply in states that do not have their own laws setting out-of-network rates. Any payments made by the patient would count toward their in-network deductibles and out-of-pocket maximums.
- Providers could not send patients a balance bill for any amounts that exceed the cost-sharing requirement in those scenarios.

**Enforcement:** States could enforce the balance billing requirements. HHS may step in if it determines a state has not substantially enforced them. HHS could impose civil monetary penalties of as much as $10,000 per violation. The penalties could be waived if the provider did not knowingly violate the requirements, withdraws the bill within 30 days, and reimburses the health plan or patient with interest. HHS also could issue hardship exemptions from the penalties.

**Payment Rates**

- Health insurers would pay providers an initial amount, or send a notice of a denial of payment, within 30 days of receiving a bill. They would ultimately have to pay a total amount that is the difference between the out-of-network rate and the patient's cost-sharing amount for those services.
- In states that do not have their own systems, the out-of-network rate would be the amount that the provider and insurer agree to through an open negotiation process, or the amount set through an arbitration process (see below).
- The Health and Human Services, Labor, and Treasury departments will issue rules that include a methodology for health plans to determine median in-network rates, the information the plan must share with out-of-network providers, the geographic regions involved, and a process to receive complaints about violations.
- The departments will create a process to audit health insurance plans to ensure they comply with requirements to apply median in-network rates for patients.

**Dispute Resolution**

- The law establishes a dispute resolution process in states that don't have their own systems. Providers and insurers will have 30 days from the initial payment or payment denial to initiate "open negotiations" to determine an amount for the service.
- If the parties do not agree on an amount within 30 days, either one may initiate an independent dispute resolution (IDR) process, which would use a certified IDR entity to determine a final payment amount.
- Each party would submit an offer for payment to the IDR entity, which would have 30 days to choose one of the offers after considering factors, including:
    - The median in-network rates for comparable services in the area.
    - Additional circumstances, such as the provider's experience and quality measures, the market share held by the provider or health insurer, the acuity of the individual being treated, the teaching status of a facility, efforts made by either party to enter into network agreements, and contracted rates in the last four years.
    - Any other information that the parties submit with their offers.
    - "Usual and customary charges;" the amount that otherwise would have been billed; or payment rates from public payers such as Medicare, Medicaid, or TRICARE will not be considered.
- The IDR entity's determination is binding and not subject to judicial review, unless fraud, misrepresentation, or other misconduct is involved.
- The party that initiates the process may not initiate another one on the same item or service with the same party within 90 days of a determination.
- The party whose offer is not chosen generally pays for all fees charged by the IDR entity. Each party would also have to pay a fee to the departments for participating in the IDR process to offset the costs of carrying it out.

**Other Provisions**

- Similar provisions apply to air ambulances.
- Requires timely updates to insurer directories.
- Establishes price disclosure requirements for both insurers and providers.
- Establishes arbitration process for uninsured patients.

*For additional information or questions, please contact Diane Turpin, Esq., General Counsel, at diane.turpin@shcare.net.*