

January 14, 2021

Detailed Summary of No Surprises Act

Comprehensive Legislation to Address Surprise Medical Billing at the Federal Level

At A Glance

The Issue:

On Dec. 27, 2020, the No Surprises Act was signed into law as part of the [Consolidated Appropriations Act of 2021](#) (H.R. 133; Division BB – Private Health Insurance and Public Health Provisions). The No Surprises Act addresses surprise medical billing at the federal level. Most sections of the legislation go into effect on Jan. 1, 2022, and the Departments of Health and Human Services, Treasury, and Labor are tasked with issuing regulations and guidance to implement a number of the provisions.

Our Take:

The hospital and health system field strongly supports protecting patients from surprise medical bills. The AHA is pleased that Congress rejected approaches that would impose arbitrary rates on providers, which could have significant consequences far beyond the scope of surprise medical bills and impact access to hospital care. We also applaud Congress for rejecting attempts to base rates on public payers, including Medicare and Medicaid, which historically pay far less than the cost of delivering care. We believe this legislation is an important step forward in protecting patients.

What You Can Do:

Review this advisory and share it with your senior management team and hospital staff.

Further Questions: If you have questions, please contact AHA at 800-424-4301.

Key Takeaways

Among many other provisions, the No Surprises Act:

- Protects patients from receiving surprise medical bills resulting from gaps in coverage for emergency services and certain services provided by out-of-network clinicians at in-network facilities, including by air ambulances.
- Holds patients liable only for their in-network cost-sharing amount, while giving providers and insurers an opportunity to negotiate reimbursement.
- Allows providers and insurers to access an independent dispute resolution process in the event disputes arise around reimbursement. The legislation does not set a benchmark reimbursement amount.
- Requires both providers and health plans to assist patients in accessing health care cost information.

Detailed Summary of No Surprises Act

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Overview

The No Surprises Act establishes patient protections against surprise medical bills and includes several transparency and other provisions. Most sections of the legislation go into effect on Jan. 1, 2022, and the Departments of Health and Human Services (HHS), Treasury and Labor are tasked with issuing regulations and guidance to implement a number of the provisions. At the end of this document is a list of guidance and regulations required by the statute.

Short title (Sec. 101)

This section names the legislation “The No Surprises Act.”

Health insurance requirements regarding surprise medical billing (Sec. 102)

This section outlines health plan requirements with respect to coverage of out-of-network emergency services and certain non-emergency services performed by out-of-network providers at in-network facilities. These provisions apply to comprehensive individual and group health plans, including fully insured plans sold through the individual and groups markets, as well as self-funded plans (often referred to as “ERISA” plans). In general, the legislation repeats each of the following provisions nearly identically three times to make changes to each of the three relevant statutes (the U.S. Public Health Service Act, the Internal Revenue Code of 1986, and the Employee Retirement Income Security Act of 1974). These provisions are effective Jan. 1, 2022, unless otherwise noted.

Health Insurance Requirements for Emergency Services. The legislation requires health insurers to cover emergency services without any prior authorization and regardless of whether the provider is in or out of the health plan’s network. The legislation, for purposes of these provisions, defines “emergency services” to include post-stabilization services unless certain conditions are met. Those conditions include that the provider is able to transfer the individual or the provider has met the notice and consent requirements established in section 104 of the legislation (and described in more detail below).

When provided by an out-of-network provider, the health plan must cover emergency services as if they were in-network, e.g., without any more restrictive utilization management requirements and at no more than the in-network cost-sharing amount. Health plans must either pay or issue a notice of payment denial to the provider within 30 calendar days after receiving the bill for the services. The plan must reimburse the provider directly and cannot instead route payment through the patient. Any patient cost-sharing must count toward the patient’s deductible and/or out-of-pocket cost-sharing maximum as though the services were provided in-network.

A significant component of this section establishes a process that insurers must follow to calculate patient’s cost-sharing obligation in these circumstances. It also stipulates

what insurers must reimburse out-of-network providers and establishes an audit procedure for federal oversight of this provision.

Cost Sharing Determination. Health plans must follow a prescribed process for determining patient cost-sharing. This calculation will be based, in part, on new concepts called the “**recognized amount**” and the “**qualifying amount.**”

Specifically, the patient’s cost-sharing obligation is calculated from the recognized amount. For example, if the patient generally owes 20% co-insurance for emergency services, the 20% is applied to the recognized amount. The legislation establishes the recognized amount as one of the following, based on the specific scenario: the amount required under any state law that applies to that patient situation and service (i.e., state surprise medical billing law); the amount established through an all-payer rate setting model (i.e., as in Maryland), or the qualifying payment amount. In other words, the qualifying payment amount is used for determining patient cost-sharing unless another state law or policy applies. The qualifying amount will likely apply in many, if not all, instances given that not all states have surprise medical billing laws and those that do often do not impact non-state regulated products.

The qualifying payment amount is determined based on historic rates between the plan and the provider or, if unavailable, an independent database of historic payment rates for such items and services. Specifically, the qualifying amount will be set based on the median contract rate recognized by the health plan on Jan. 31, 2019 within the same insurance market (e.g., cannot consider Medicare Advantage rates when establishing the qualifying payment amount for an enrollee in an individual market plan). This amount is trended forward to the applicable year. If the plan is new and did not offer coverage in 2019 or otherwise does not have sufficient information to calculate the qualifying amount, the plan must use either the median contract rate from the first plan year that they began covering such item or service or information from an independent database, such as an all-payer claims database.

The legislation directs the Secretary of HHS, in consultation with the Secretaries of Labor and Treasury, to issue regulations no later than July 1, 2021 to establish the qualifying amount. The HHS Secretary must account for a number of factors, including the particular insurance market (individual, small group, large group) and the geographic area taking into account whether the services were delivered in a rural or underserved area, such as a health professional shortage area. The regulations must identify the information that health plans must share with providers and establish a process to receive complaints about any health plan violations. In addition the HHS Secretary must take into account payments that are not made on a fee-for-service basis and provider characteristics that may impact reimbursement rates, such as a facility’s case mix. In addition, the HHS Secretary must consult with the National Association of Insurance Commissioners on the geographic considerations.

Provider Reimbursement. The legislation defines the “**out-of-network rate**” as what the health plan pays the out-of-network provider for services subject to these provisions.

The rate will depend on certain circumstances, such as whether the service is subject to a state law that establishes the reimbursement amount or process for determining the reimbursement amount or the service was delivered in a state with an all-payer rate-setting model. If neither of those two scenarios apply, then the out-of-network rate is either the rate agreed to by both the plan and provider or, in the event the provider and plan cannot agree, the rate determined through the independent dispute resolution process (see Section 103).

Health Plan Audits. The HHS Secretary, in consultation with the Secretaries of Labor and Treasury, shall through rulemaking establish the audit process no later than Oct. 1, 2021. Audits are limited to no more than 25 health plans annually; however, the Secretaries may audit any plan based on a complaint or other information questioning compliance with these provisions. The HHS Secretary must submit annual reports to Congress on the number of plans that were audited.

Non-Emergency Services Performed by Out-of-Network (Nonparticipating) Providers at In-network (Participating) Facilities. The legislation also provides protections against surprise medical bills when a patient is seen by an out-of-network provider in an in-network facility in certain circumstances. Specifically, health plans must assess patient cost-sharing for these services as if they were in-network and compensate the provider similar to as described above. However, there is a notable exception in instances where the provider has obtained consent from the patient consistent with the notice and consent requirements established in Section 104.

Patient Access to Pediatric, Obstetrical and Gynecological Care. This section of the legislation also includes provisions to help ensure access to pediatric, obstetrical and gynecological care. Specifically, pediatricians must be able to serve as a child's primary care provider, and plans must ensure that enrollees are able to access obstetrical and gynecological care without having to go through an approval process instituted by the plan.

Determination of out-of-network rates to be paid by health plans; Independent dispute resolution (IDR) process (Sec. 103)

Reimbursement for out-of-network services may be determined in one of several ways. The legislation defers to state law or policy if applicable. If no such policy applies, then the legislation defines the process through which reimbursement is determined. First, the provider may accept the initial payment made by the plan. Second, the health plan and provider may come to a mutually agreeable amount through routine negotiating procedures during a 30-day period beginning the day the provider receives the initial payment (or payment denial) from the plan. Finally, should either of these fail, the parties may bring an outstanding dispute to an IDR process established under this section of the law. However, the parties can continue to negotiate during the IDR process and do not need to complete it if they can agree to reimbursement during this period. These provisions are effective Jan. 1, 2022 unless otherwise noted, and the Secretaries of HHS, Labor, and Treasury must jointly issue regulations establishing an IDR process by Dec. 27, 2021.

IDR Process and Timeline. If a provider and health plan cannot come to agreement on reimbursement, either party may trigger the IDR process (referred to as “notifying”) within four days of the conclusion of the 30-day open negotiation period. The plan and provider then have three business days to jointly select the IDR entity to oversee the case; should that fail, the HHS Secretary has up to three business days to select one on their behalf. Within 10 days of the selection of the IDR entity, each party must submit an offer for reimbursement, as well as any supporting materials. The IDR entity must select one of the offers without modification as the final reimbursement determination within 30 days of the IDR entity having been selected. Once a determination has been reached in a case, the payer must remit reimbursement to the provider within 30 days.

The party that submitted the notification to initiate the IDR process may not submit another case for the same item or service involving the same other party during a 90-day period after the initial notification. This is frequently referred to as a “cooling off” period. However, the party may hold such claims and then submit them for IDR within the four-day period after the 90-day “cooling off” period is over. The statute provides the HHS Secretary with significant discretion to modify the timelines applicable to these provisions.

Factors Arbiters May Consider. Arbiters are directed to consider a number of factors when making their payment selection, including the qualifying payment amount for the applicable item or service (see above) and, at either the request of the IDR entity or as part of voluntary submission by the plan or provider, information on: the level of training, experience, quality and outcomes of the provider; the market share held by the provider and/or the plan; patient acuity; teaching status, case mix, and scope of services of the provider; demonstrations of good faith efforts to enter into a network agreement with the other party; and, if applicable, past contracted rates between the parties during the previous four years. IDR entities may not consider provider charges or rates paid by public programs, such as Medicare, Medicaid, the Children’s Health Insurance Program or TRICARE.

Batching of Items and Services. Providers may batch together like claims attributable to the same health plan that occur during a 30-day period. However, the Secretaries, via regulation, will provide additional details on the criteria for such claims and may, according to the statute, modify the timeframe for batching.

Fees. The party that submits the losing bid is responsible for the costs of the IDR process unless the dispute is resolved between the two parties prior to the conclusion of the process. In that case, the parties split whatever costs have been incurred by the IDR entity to that point. The statute also references administrative fees to be paid to HHS by both parties; however, it is unclear at this time whether those fees are separate from what is paid to the IDR entity and whether the losing party must pay those fees as well.

Reports. The Secretaries must submit an interim report to Congress within two years (final within four years) evaluating whether the 90-day period during which similar claims

cannot be submitted results in delays in payment or abuses by health plans, e.g., creating patterns of claims denial, down-coding or low-payment.

Public Posting of Information. The HHS Secretary must post publicly certain information about the IDR process on a quarterly basis, and the IDR entities are required to provide this information to the HHS Secretary for this purpose. Beginning in 2022, the HHS Secretary must post information on: the number of requests for IDR (“notifications”); the size of the provider practices or facilities submitting notifications; the number of cases that resulted in the IDR making a determination (versus being settled between the two parties); a description of the item or service at issue; where (geographically) the item or service was delivered; the amount each party offered through the IDR process; which offer was selected; the identity of the parties; the category and practice specialty of the provider or facility; the length of time it took the arbiter to make a determination; the compensation paid to the IDR entity; the amount HHS has expended to carry out the IDR process; and other information as specified by the HHS Secretary. The statute does limit the HHS Secretary from posting certain privileged or confidential information.

Selection of IDR Entities. The statute outlines several eligibility criteria for IDR entities but directs the Secretaries of HHS, Labor, and Treasury to establish a process for certification through regulation. The law requires that the IDR entities have relevant medical and legal expertise, as well as sufficient staffing to make determinations on a timely basis. The organization cannot be biased, e.g., a health plan, provider, or association of either plans or providers, and must meet other requirements, including certain fiscal integrity and confidentiality requirements. The Secretaries shall ensure that a sufficient number of entities are chosen to ensure timely determinations, and entities will be certified for a 5-year period, subject to revocation for noncompliance with any requirements.

Health care provider requirements regarding surprise medical billing (Sec. 104)

Beginning Jan. 1, 2022, out-of-network health care providers (including facilities, physicians and non-physician practitioners) may not balance bill patients for covered emergency services or certain covered non-emergency services provided at in-network facilities unless certain conditions are met. In other words, patient cost-sharing must be limited to no more than the patient would have had to pay had the provider been participating in the patient’s health plan network. For purposes of this section, the definition of “emergency service” from Section 102 applies.

The majority of this section focuses on the notice and consent process and, specifically, which non-emergency services are subject to the prohibition on balance billing in all circumstances and those for which an out-of-network provider may bill the patient more in cost-sharing with appropriate notification and consent by the patient. However, it also includes important requirements with respect to enforcement, as well as patient notification about balance billing protections.

Notice and Consent Process and Requirements. An out-of-network provider may balance bill a patient for items or services if they satisfy the notice and consent process established under the law. However, the notice and consent process may not be used for certain services, including emergency services, certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received.

Written notice and consent must be received within 72 hours of the item or service being delivered or, if the item or service is scheduled within that timeframe, at the time the appointment is made. The notice can be in paper or electronic form (as selected by the patient) and must contain the following information at a minimum: notification that the provider is out-of-network; a good faith estimate of the charges; a list of in-network providers at the facility (if the facility is in-network) to which the patient can be referred; information on any prior authorization or other care management requirements; and a clear statement that consent is optional and the patient can instead opt for an in-network provider. The notice must be available in the 15 most common languages spoken in the provider's area. The HHS Secretary must issue further guidance on these requirements by July 1, 2021, including specifying the form to document patient consent. However, the legislation requires that this form, at a minimum, includes a space to obtain the patient's signature agreeing that they were provided with appropriate notice, including a cost estimate, as well as the date on which notice was provided and consent obtained.

Facilities are generally responsible for maintaining consent documents, including for unaffiliated out-of-network clinicians delivering services in their facility. Record of notice and consent must be retained for seven years after the date on which the item or service was delivered.

Ancillary Services for Which Notice and Consent Option Does Not Apply. Patients receiving the following nonemergency ancillary services may not be billed beyond their in-network cost-sharing amount. In other words, the above notice and consent option cannot be used for these services. These include items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology, as well as diagnostic services (including radiology and laboratory services). In addition, an out-of-network provider cannot use the notice and consent process if there is no in-network provider available to furnish the item or service at the facility. Finally, the legislation gives the HHS Secretary discretion to add additional items and services to this list through rulemaking, or to remove certain advanced diagnostic laboratory tests.

Provider Disclosure of Balance Billing Protections. Beginning Jan. 1, 2022, all health care providers must make publicly available information on patients' rights with respect to balance billing. This notice also should be available on the providers' public websites. The notice must contain information on the requirements established under this law, information on any state-level protections if applicable, and contact information for state and federal agencies to report any potential violations.

Enforcement of Provider Requirements. The legislation permits states to require providers to adhere to these provisions and enforce compliance. Absent state action against any violation, the Secretaries of HHS, Labor, and Treasury each play a role in enforcement, with the HHS Secretary able to issue civil monetary penalties of up to \$10,000 per violation. The HHS Secretary may waive these penalties, however, if the provider unknowingly violated the provisions (and could not have reasonably known in advance), withdraws the bill, and reimburses the patient (or plan, as appropriate) with interest. In addition, the HHS Secretary has authority to issue hardship exemptions.

The Secretaries of HHS and Labor each have additional responsibilities to establish by Jan. 1, 2022 a process to receive consumer complaints, and, in the case of the Secretary of Labor, transmit these complaints to the HHS Secretary for potential enforcement. The Secretary of Labor also must monitor violations of these requirements and identify if any patterns of violations on the part of plans is occurring and take appropriate steps to correct these violations.

Ending surprise air ambulance bills (Sec. 105)

This section establishes that patients using air ambulance services (defined as medical transport using helicopter or airplane) would be accorded similar consumer protections against surprise medical billing for emergency services. Patients would be required to pay only the in-network cost-sharing amount for out-of-network air ambulances and could count the cost sharing toward their deductible. Beginning Jan. 1, 2022, out-of-network air ambulance providers would be barred from sending patients balance bills for more than the in-network cost-sharing amount.

A 30-day negotiation period would be available for out-of-network air ambulance providers and health plans to settle disputed claims after the out-of-network air ambulance provider receives payment or a payment denial notice. In the event the involved parties fail to reach an agreement, either party could invoke IDR following a similar process established for non-ambulance providers and health plans (as described in Sec. 103). The Departments of HHS, Labor, and Treasury are required to issue implementing regulations one year after enactment.

Reporting requirements regarding air ambulance services (Sec. 106)

The legislation requires air ambulance providers to meet new cost and claims reporting requirements. The information that must be submitted to HHS and the Department of Transportation (DOT) include: the number of emergency and non-emergency air ambulance transports disaggregated by air ambulance base and type of aircraft; payer mix; patient insurance status; claims denials; geographic area of service; and ownership or sponsorship (public for private) of air ambulance services. HHS and DOT will issue rules to govern report requirements and public reports within one year of enactment, and reporting requirements would commence within 90 days of implementation of the final rule. In addition, HHS and DOT would issue a public report based on the information collected that assesses matters such as: market concentration; gaps in geographic coverage; average charges by air ambulance providers; claims denials by health plans; patient billing collection practices, including liens and garnishment of

wages; and quality and safety information. Air ambulance providers are subject to civil monetary penalties for failure to report this information, and the DOT Secretary can use the information reported to determine if such providers are in violation of other federal statutes. Within 60 days of enactment, HHS and DOT shall establish an advisory committee tasked to review and make recommendations to Congress related to air ambulance quality, patient safety and clinical standards.

Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations (Sec. 107)

This section requires health plans offering group and individual health insurance coverage to include new information on insurance identification cards for plan years beginning on or after Jan. 1, 2022, including:

- All plan deductibles, including in-network and out-of-network deductible amounts, as applicable.
- Maximum limits on out-of-pocket costs, including in-network and out-of-network out-of-pocket cost limits, as applicable.
- A telephone number and web address for consumer assistance information, including information on in-network providers.

Implementing protections against provider discrimination (Sec. 108)

This provision requires that the Departments of HHS, Labor, and Treasury to issue rules no later than Jan. 1, 2022, to implement changes made by the Affordable Care Act (ACA) to the Public Health Service (PHS) Act protections against provider discrimination. The provider discrimination protections included in the ACA are currently implemented through subregulatory guidance only. These protections state that health plans offering coverage shall not discriminate with respect to participation under the plan against any health care provider who is acting within the scope of that provider's license or certification under applicable state law. Health plans are not required under this section of the PHS Act to contract with any willing health care provider nor does this section prevent health plans or HHS from establishing varying reimbursement rates based on quality or performance measures. Final regulations implementing this section of the PHS Act are required within 60 days after the conclusion of the proposed rule public comment period.

Reports (Sec. 109)

This section instructs several federal agencies to conduct reports on the implications of the No Surprises Act as it relates to market consolidation of health plans and providers, provider network adequacy, consumer out-of-pocket costs and the IDR process. These reports are summarized below.

- **HHS in consultation with Federal Trade Commission (FTC) and Department of Justice (DOJ):** No later than Jan. 1, 2023 and annually for the next four years HHS in consultation with FTC and DOJ shall issue a report to Congress that examines and makes recommendations on the effects of the Act. The report will

specifically focus on vertical and horizontal integration of health plans and providers, implications for overall health care costs, and implications for access to care, especially in rural and professional shortage areas.

- **Government Accountability Office (GAO) reports on the impact of surprise medical billing.** The GAO will issue three reports to Congress that examine the impact of the new law. The first report, to be issued no later than Jan. 1, 2025, would examine how the law impacts health plan provider networks, specialty care and consumer out-of-pocket costs. In its work, GAO is instructed to use a statistically significant sample of health care providers and health plans to examine, among other things, provider participation in specialty care and underserved and rural areas. The second report requires that GAO issue legislative recommendations by no later than Jan. 1, 2023 to improve provider network adequacy. The third report requires GAO to review the IDR process, examining among other things the financial arrangements between providers and facilities utilizing the IDR process. This report is due no later than Dec. 31, 2023.

Consumer protections through application of health plan external review in cases of certain surprise medical bills (Sec. 110)

The legislation establishes an external review process to determine whether a health plan was correct in instances of determining that the surprise medical billing protections do not apply.

Consumer protections through health plan requirement for fair and honest advance cost estimate (Sec. 111)

This section establishes new requirements for health plans offering group and individual health insurance coverage to send patients “Advanced Explanations of Benefits” (EOB) prior to scheduled care or upon request by patients seeking more information prior to scheduling. The Advanced EOB requirement is triggered by the provider sending a “good faith estimate,” as required in Section 112, to the plan. A patient also may request an Advanced EOB from their health plan. The legislation lays out eight components for the Advanced EOB:

- Information on whether the provider or facility delivering the item or service are in-network for that particular item or service, based on the patient’s health plan.
 - If the provider or facility is in-network, the health plan will need to include the contracted rate for the item or service, based on the billing and diagnostic codes sent by the provider.
 - If the provider or facility is out-of-network, the health plan will need to include a description of how the patient could obtain information on in-network providers delivering that item or service.
- The “good faith estimate” of expected charges, including likely billing and diagnostic codes, sent by the provider or facility.
- A “good faith estimate” of the plan’s payment responsibility.

- A “good faith estimate” of the patient’s expected cost-sharing amount (based on the notification date and not the date of service).
- A “good faith estimate” of the amount the patient has incurred toward meeting their financial responsibility limits, such as their deductible and out-of-pocket maximums.
- A disclaimer that coverage for the item or service is subject to a certain medical management technique (e.g., prior authorization), as appropriate.
- A disclaimer that all information included in the notice is an estimate based on the information known at the time of scheduling or requesting the information and is subject to change.
- Any other information or disclaimers the health plans determine is appropriate for this notice.

Health plans will need to share this information by mail or electronically based on patient preference within three business days of receiving a request or notice that a service had been scheduled, as long as the service is scheduled for at least 10 business days after the notice. If the services is scheduled for less than 10 days after the notice, the health plan will need to provide this information within one business day. The HHS Secretary will have the authority to modify the timing requirements for services deemed to have low utilization or significant variations in costs. This requirement is effective for plan years beginning on or after Jan. 1, 2022.

Patient protections through transparency and patient-provider dispute resolution (Sec. 112)

This section establishes a new requirement for health care providers (both individual practitioners and facilities) to share “good faith estimates” of the total expected charges for scheduled items or services, including any expected ancillary services, with a health plan (if the patient is insured) or individual (if the patient is uninsured). The notice also will need to include the expected billing and diagnostic codes for all items and services to be provided. This requirement will apply whenever items or services are scheduled at least three days in advance or when requested by a patient. The provider will need to determine the patient’s health coverage status and develop the “good faith estimate” at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider will need to furnish the information within three business days of a patient requesting an estimate or scheduling a service. This requirement will go into effect Jan. 1, 2022.

In addition, the legislation directs the HHS Secretary to establish a “patient-provider dispute resolution process” by Jan. 1, 2022, to adjudicate any disputes over pricing for uninsured patients that receive a substantially higher bill than the “good faith estimate” provided prior to service. The rulemaking will include a method for selecting and

certifying IDR entities and an administrative fee for participating in the dispute resolution process that will not create an access barrier for uninsured individuals.

Ensuring continuity of care (Sec. 113)

This section of the law provides for continuity of services for enrollees of health plans when there is a change in the plans' provider network. These protections extend to individuals defined as a "continuing care patient" and include patients who are undergoing a course of treatment for a serious or complex condition, undergoing institutional or inpatient care, scheduled to undergo non-elective surgery including post-operative care, pregnant and undergoing treatment, or terminally ill and receiving services. Plans are required to ensure continuing care patients receive timely notification of changes in the network status of providers and facilities. Such patients will have up to 90 days of continued coverage at in-network cost sharing to allow for a transition of care to an in-network provider.

Maintenance of price comparison tool (Sec. 114)

This section establishes a new requirement for health plans to maintain online price comparison tools that will allow patients to compare expected out-of-pocket costs for items and services across multiple providers. Health plans also will need to provide price comparisons over the phone. Health plans will need to offer such price comparisons for plan years beginning on or after Jan. 1, 2022.

State all payer claims databases (Sec. 115)

This section establishes grants for states to create or improve All Payer Claims Databases. Funding will be awarded over a three-year period (\$1 million for each of the first two years, and \$500,000 for the last year). The section defers to the HHS Secretary to create application requirements, which at a minimum must include specifications on how a state will ensure uniform data collection and the privacy and security of such data. States are required to make the data available to researchers and other stakeholders (e.g., providers, health coverage issuers, etc.) for the purpose of quality improvement or cost containment.

This section also requires the HHS Secretary to establish (and periodically update) a standardized reporting format for voluntary reporting by group health plans to state APCDs within one year of the date of enactment. This section also requires the HHS Secretary to provide guidance to states on the process by which states may collect data from group health plans in the standardized format. The HHS Secretary will establish an advisory committee (within 90 days), which includes a variety of federal government and other stakeholders who are likely to submit data or to use the database, to advise the Secretary regarding standardized format.

Protecting patients and improving the accuracy of provider directory information (Sec. 116)

Beginning for health plan years on or after Jan. 1, 2022, plans will be required to establish a verification process to ensure accurate provider directories, a response protocol for individuals inquiring about the network status of a provider, and a publicly accessible provider database. These provider directory requirements do not pre-empt existing state law, and patients that relied on inaccurate provider directory information would only be subject to the in-network cost sharing amounts. The law requires that health plans verify and update provider directory information no less than every 90 days (or within two days of receiving notice of a change), as well as establish a procedure for removal of providers who are no longer in network. Plans are required to respond to individuals inquiring about the network status of a provider or facility within one business day of the inquiry and must retain records of the inquiry for two years. Plans must have a web-based provider directory that includes the provider and facility contact information, specialty information, direct or indirect contractual relationship with the plan, and digital contact information. Health plans also will be required to make information available on their websites and through other plan communications regarding balance-billing protections. Such information also must include the appropriate federal and state contact information for consumers to report any violations. Plans also are required, where state law applies, to provide information regarding allowable charges by non-contracting providers or facilities and any consumer cost-sharing obligations.

Advisory committee on ground ambulance and patient billing (Sec. 117)

This section requires that the Departments of HHS, Labor, and Treasury, no later than 90 days after enactment, form an advisory committee on ground ambulance patient billing. The advisory committee is instructed to examine options to improve the disclosure of charges and fees for ground ambulance services, better inform consumers of insurance options for such services, and protect consumers from balance billing. The composition of the advisory committee would include individuals from relevant federal, state and local government agencies, emergency personnel, health insurers, consumer advocates, and members from the ground transportation industry. The advisory committee is required to report to Congress, within six months of convening, a set of recommendations for ground ambulances to include patient billing best practices, recommendations for state governments on ensuring consumer protections, and legislative recommendations for Congress to prevent balance billing.

Implementation funding (Sec. 118)

This section establishes federal funding to support implementation of the No Surprises Act. An amount of \$500 million is appropriated for FY 2021 and can be used until FY 2024 for the Departments of HHS, Labor and Treasury. Permitted purposes of the appropriated funds include preparing implementing regulations and guidance, reports, audits, enforcement, data collection and the establishment of the IDR process. HHS, Labor, and Treasury must report to Congress annually on the use of the implementation funding.

Regulatory/Guidance Calendar

Section	Future Regulations and Guidance	Agency(ies)	Due Date
102	Establish the qualifying amount	HHS, in consultation with Labor and Treasury	July 1, 2021
	Establish process to audit health plans for compliance	HHS, in consultation with Labor and Treasury	Oct. 1, 2021
103	IDR process	HHS, Labor, and Treasury	Dec. 27, 2021
104	Notice and consent	HHS	July 1, 2021
	Consumer complaint process	HHS, Labor	Jan. 1, 2022
105	Air ambulance IDR process	HHS, Labor	Dec. 27, 2021
106	Air ambulance provider reporting requirements implementing rules	HHS, Transportation	Dec. 27, 2021
	Air Ambulance Advisory Committee	HHS, Transportation	Feb. 27, 2021
107	Transparency requirements for plans on out of network cost-sharing	HHS	Undefined (applies to health plan year Jan. 1, 2022)
108	Protections against provider discrimination regulation	HHS, Labor, Treasury	By Jan. 1, 2022
109	Report on consolidation, health care costs, access	HHS, FTC, Justice	By Jan. 1, 2023, and annually for each of the following 4 years
	Report on implications of the law	GAO	Jan. 1, 2025
	Report on provider network adequacy	GAO	Jan. 1, 2023
	Report on IDR process	GAO	Dec. 1, 2023
111	Advanced EOB timing requirements for items and services that have low utilization or significant variations in cost	HHS	At Secretary's discretion
112	Patient-provider dispute resolution process	HHS	Jan. 1, 2022
113	Ensuring Continuity of Care	HHS	Undefined
115	APCD state grant process	HHS	Undefined
	APCD standardized reporting format for ERISA claims	HHS	Dec. 27, 2021
116	Provider directory requirements	HHS	Undefined (applies to health plan year Jan. 1, 2022)
117	Ground Ambulance Advisory Committee	HHS, Labor, Treasury	March 27, 2021