Proskauer

No Surprises: Congress Enacts Surprise Bill Law and Adds Mandatory Billing Transparency

January 7, 2021

The recently enacted Consolidated Appropriations Act, 2021 (the "Act") not only funds the government and provides further relief in regard to the impact of the COVID-19 pandemic, but it also adopted a number of new substantive laws. We summarize below two key categories of new substantive law contained in the Act: (1) the prohibition on surprise medical billing; and (2) requirements related to price transparency.

1. Prohibition of Surprise Billing

A. Prohibition

Effective January 1, 2022, patients will be protected from unexpected or "surprise" medical bills that could arise from (1) out-of-network emergency care (including certain ancillary services routinely available in an emergency department) provided at an out-of-network facility or at in-network facilities by out-of-network providers; and (2) out-of-network nonemergency care provided at in-network facilities without the patient's informed consent. Many states have passed similar legislation, but the federal government has been working to enact a ban on surprise billing for quite some time.

Under the "No Surprises Act," patients are only required to pay the in-network cost-sharing amount, which will be determined through a formula established by the HHS Secretary and will count toward the patient's health plan deductible and out-of-pocket cost-sharing limits. Providers will generally not be permitted to balance bill patients beyond this cost-sharing amount. An out-of-network provider will only be permitted to bill a patient more than the in-network cost-sharing amount for care if the provider gives the patient notice of the provider's network status and delivers to the patient or their health plan an estimate of charges within certain specified timeframes, and obtains the patient's written consent prior to the delivery of care. Providers that violate these surprise billing prohibitions may be subject to state enforcement action or federal civil monetary penalties of up to $10,000.

In the first instance, states are explicitly permitted to enforce the No Surprises Act. If states fail to "substantially enforce the requirements" of the No Surprises Act, then HHS is obligated to do so. This approach could potentially result in uneven enforcement of the bill's protections.

Furthermore, the No Surprises Act extends application of health plan external review procedures to cases where a health plan has made an adverse determination regarding certain surprise medical bills.

B. Arbitration Process

The No Surprises Act also implements an independent dispute resolution ("IDR") process, which out-of-network providers may utilize if they disagree with a payment made by a health plan for services subject to the surprise billing protections described above. If the provider and the health plan cannot resolve the dispute within 30 days, the parties can trigger the IDR process within four days of the end of the negotiation period. The IDR process will be conducted by a neutral arbiter approved by the federal government. Each party must submit a final offer for consideration by the arbiter.

The arbiter will consider relevant information, including: the median contracted in-network rate; the provider's training and experience; the patient's acuity and the complexity of care provided; the facility's teaching status, case mix and scope of services; any demonstration of good faith effort or lack thereof to resolve the dispute; prior year contracted rates; and other information brought forward by the involved parties. Importantly, the arbiter will not be able to consider the provider's usual and customary or billed charges or the rates paid by federal health care programs, such as Medicare or Medicaid.

The arbitration process must conclude within 30 days, and the losing entity will be required to pay all fees associated with participating in the IDR process. We anticipate HHS and the Department of Labor (for ERISA plans) to engage in the notice and comment process within the next six months to establish regulations on the IDR process.

C. Interaction with State Laws

To date, approximately 22 states have enacted protections against surprise billing. While some state laws are more comprehensive than others, states cannot regulate ERISA health plans and thus cannot fully protect all consumers. The No Surprises Act will therefore extend surprise billing protections to ERISA plan beneficiaries, as well individuals in states without protections. In addition, as noted above, states are explicitly empowered to enforce the No Surprises Act and if they do so, they will be the primary mechanism of enforcement.

Note that the No Surprises Act defers to existing state laws with respect to state-established payment amounts and dispute resolution procedures for state-regulated health plans. Therefore, if a state law already sets a payment amount for a surprise medical bill dispute, the state's payment mechanism would continue to govern disputes between insurers and out-of-network providers in that state for the fully insured plans they are able to regulate.

Given that there will soon be two systems in place – (1) the No Surprises Act applicable to ERISA plans and states without specific surprise billing prohibitions; and (2) state law applicable to fully insured plans – implementation and enforcement may prove to be difficult. Moreover, providers may be confused as to which system applies for a given patient.

2. Transparency

A. Provider Price Transparency

The Act includes certain provider transparency measures, also effective January 1, 2022, that dovetail with the prohibition on surprise billing to improve consumers' access to information.

Among other provisions, the Act requires an out-of-network provider to deliver to the patient's health plan (or directly to the patient if uninsured) a "good faith estimated amount" of all billing and service codes for all items and services expected to be furnished to the patient, prior to obtaining the patient's consent to treatment. This represents a significant change from current practice and imposes a substantial administrative burden on providers. Providers must share such estimates with the relevant party at least three days prior to rendering the scheduled services and within one day of scheduling, unless the services are scheduled more than 10 days later (in which case the provider must disclose such information within three business days of scheduling). Furthermore, the HHS Secretary must establish by January 1, 2022 a "patient-provider dispute resolution process" to resolve any disputes concerning bills received by uninsured individuals that substantially differ from a provider's good faith estimate provided prior to the service being rendered.

The Act contains additional new transparency measures, such as mandating that providers make publicly available on their website a short explanation of federal and state requirements and prohibitions related to balance billing. This explanation must include contact information for relevant enforcement agencies aggrieved patients may contact to file complaints.

The HHS Secretary is empowered to establish a formal consumer complaint process through future notice and comment rulemaking, which we expect HHS to initiate within the next six months.

B. Health Plan Benefits and Price Transparency

The Act implements new requirements for health plans that bolster price transparency and improve consumers' access to health plan information. Significantly, beginning January 1, 2022, health plans must provide enrollees with "Advanced Explanation of Benefits" ("AEOB") prior to scheduled care or upon patient request prior to scheduling. The AEOB requirement is triggered by a provider sending the health plan a "good faith estimated amount" for such scheduled services, and must contain the network status of the provider, information on prior authorizations, and estimates of any applicable rates, the enrollee's expected out-of-pocket expenses, the health plan's expected expenses, and the amounts already incurred towards the enrollee's out-of-pocket limits. While a health plan must send the AEOB either within three days of receiving a request or a notice that a service that is scheduled at least 10 business days later, or within one business day of receiving the notice if the service is scheduled within 10 business days of receipt, the Act grants the HSS Secretary the authority to modify such timing for certain services.

The Act also aims to empower consumers to more effectively shop for medical services. Under it, health plans must maintain price comparison tools available both online and over the phone for plan years beginning January 1, 2022. The Act also mandates that health plans maintain up-to-date in-network provider directories; an enrollee's documented reliance on an outdated directory will result in the individual being responsible only for the in-network cost-sharing amount. These supplement other transparency measures included in the Act that improve consumers' access to information, such as provisions requiring an enrollee's insurance card to identify their in- and out-of-network deductibles and out-of-pocket maximums.

Additionally, the Act regulates elements of health plan contracts with both providers and enrollment assistance services. It prohibits “gag clauses” in agreements between health plans and providers, which clauses directly or indirectly restrict a health plan from disclosing, and a plan sponsor, referring provider, or group or individual market consumer from accessing, provider-specific price, cost, or quality data. This gag clause prohibition extends to contractual terms that would bar access to de-identified service codes, claims and encounter data, and provider information. Critically, though, the Act permits a provider to place “reasonable restrictions” on the public disclosure of the information subject to the gag clause prohibition; the bounds of such restrictions remain undefined and subject to interpretation. The Act further regulates health plan contracts by requiring brokers of and consultants to employer-sponsored, individual market, and short-term limited duration health plans to disclose any direct and indirect compensation they may receive for enrollment services.

Underscoring the push for increased price transparency, the Act imposes new obligations on health plans to report, among other data, plan-specific prescription drug spending and hospital spending information to the HHS, Labor, and Treasury Secretaries. These disclosures will inform new tools detailing drug pricing trends that will be published on the HHS website and available to consumers.

* * *

Proskauer's cross-disciplinary, cross-jurisdictional Coronavirus Response Team is focused on supporting and addressing client concerns. We will continue to evaluate the CARES Act, the Consolidated Appropriations Act, 2021, related regulations and any subsequent legislation to provide our clients guidance in real time. Please visit our Coronavirus Resource Center for guidance on risk management measures, practical steps businesses can take, and resources to help manage ongoing operations.

Related Professionals

- **Edward S. Kornreich**