Surprise Billing in the Consolidated Appropriations Act, 2021: Details and Analysis of Process

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Introduction

Surprise billing describes a situation when an insured patient unknowingly receives care from an out-of-network provider and then is presented with a bill for services and payment obligation beyond what the patient's insurer will cover. Surprise medical bills can arise in an emergency when the patient has no ability to select the facility or provider rendering services. Surprise bills can also arise when a patient receives planned care, such as when a patient receives care at an in-network facility but later finds out that a provider who treated the patient is out-of-network. This most often happens with providers with whom the patient does not interact prior to the service, such as pathologists and radiologists.

Surprise billing has been a priority issue for Congress for more than two years. In 2019, policymakers across five major healthcare committees (the US Senate Finance Committee; the Senate Health, Education, Labor, and Pensions (HELP) Committee; the US House of Representatives Education and Labor Committee; the House Energy and Commerce Committee; and the House Ways and Means Committee) and both chambers developed and considered multiple surprise billing proposals. Although the proposals overlapped in some areas and early 2020 saw momentum toward resolution, the outbreak of the COVID-19 pandemic shifted congressional focus.

Negotiations heated up again when lawmakers began working on an end-of-year legislative package for 2020. In the end, a compromise was reached and surprise billing provisions were included in the Consolidated Appropriations Act, 2021 (CAA) that was signed into law on December 27, 2020.

Under the new law, beginning January 1, 2022, plans and providers (including hospitals, facilities, individual practitioners and air ambulance providers) are prohibited from billing patients more than in-network cost-sharing amounts in certain circumstances. The prohibition applies to both emergency care and certain non-emergency situations where patients do not have the ability to choose an in-network provider.

To reconcile payment disputes between plans and providers, the legislation allows negotiation between the parties and enables a prescribed arbitration process if negotiations fail. The arbitration methodology is applicable to providers and payors and, notably, to air ambulances (inclusion of air ambulance-related disputes has been one of the more contentious issues). The new law does not include a minimum negotiated payment rate to trigger arbitration, although previous iterations of the bill had set a floor.

The arbitration process is baseball-style: each party submits an offer and basis for that offer, and the mediator selects one of the offers. The decision is final, and payment must be made within 30 days. Providers and payors cannot initiate a new arbitration process for 90 days for the same items or services.

The inclusion of the surprise billing provisions is a culmination of more than two years of congressional focus and intense lobbying. This article summarizes the surprise billing provisions included in the CAA.

The US Department of Health and Human Services (HHS) will need to develop regulations to implement many aspects of the final law. Given the January 1, 2022, effective date, those regulations are expected in 2021.

Background

In 2019, Congress came close to enacting legislation addressing surprise billing of patients, the situation where a patient unwittingly receives services from an out-of-network provider and is billed and responsible for the cost of those services. As a result of intense competing lobbying efforts by stakeholders, two primary surprise billing legislative proposals circulated in late 2019. The Lower Health Care Costs Act proposed to resolve payor-provider payment disputes using a combination of benchmark rates and arbitration, and was supported by House Energy and Commerce Committee leadership Frank Pallone (D-NJ) and Greg Walden (R-OR), and Senate HELP Committee Chairman Lamar Alexander (R-TN). The second proposal, the Consumer Protections Against Surprise Medical Bills Act of 2020, also included the arbitration approach but did not include a minimum negotiated rate or a threshold amount to enter arbitration. This proposal was supported by House Ways and Means Committee leadership Richard Neal (D-MA) and Kevin Brady (R-TX). View our summary of the previous surprise billing proposals here. Finally, the text of a compromise, the No Surprises Act, was released a week prior to the final text of the CAA. Additional changes were made between release of the draft No Surprises Act and the final CAA provisions.

The surprise billing provisions in the CAA represent a significant step toward addressing the surprise billing issue. By using arbitration rather than pegging payment rates to specific benchmark rates, the legislation follows an approach preferred by providers. The final version of the CAA moves even further than the draft of the No Surprises Act in favor of doctors and hospitals by banning the arbiter from considering the lower payment rates paid by federal government programs.

The final enacted version of the CAA includes additional changes from the No Surprises Act. The CAA omitted the requirements on timely billing provisions, which would have set up a 90-day timeframe in which a patient must receive a bill after discharge or the end of a visit. If the patient did not receive the bill within 90 days, the patient would not be obligated to pay. This provision caused concern among some stakeholders, who asserted that a 90-day window was too short for plans and providers to work out payment discrepancies.

While these provisions are now law, many requirements will require agency rulemaking, including details of the independent dispute resolution process. This leaves room for input from the new Administration as well as stakeholders before the bill goes into effect in January 2022. These opportunities are highlighted throughout the document in orange. Also, here are helpful info-graphics that highlight prohibitions on surprise billing and the dispute resolution process. Expect continued lobbying of Congress and the Administration, and possibly more changes in the lead-up to implementation.

Prohibition on Balance Billing

Emergency Situations

The CAA prohibits providers and plans from balance billing patients for emergency services, regardless of the in-network or out-of-network status of the facility or provider treating the patient. Emergency services can include items and services provided to patients after they are stabilized and as part of outpatient observation, or as part of an inpatient or outpatient stay that is connected to the original emergency visit, unless certain conditions are met. The patient is only responsible for the cost-sharing amount (*i.e.*, copayments and deductibles) that would apply if the services had been provided at in-network facility and in-network provider.

Patient cost-sharing cannot be greater than the recognized amount and will count toward any in-network deductible or out-of-pocket maximums. The recognized amount may be either (1) determined by existing state law or regulation, or (2) if no state law is in place, the qualifying payment amount (defined herein by the CAA as the median contracted rate recognized by the plan as the total maximum payment provided on January 31, 2019, for the same or similar item or service, by a similar provider, in the same geographic region). HHS will need to set a methodology to determine this amount (described in more detail below), and the qualifying payment amount will be increased annually by the consumer price index.

The plan must send a payment or notice of denial of payment to the provider within 30 days of the receiving the initial bill from the provider.

HHS, in consultation with the US Departments of Labor and Treasury, must issue regulations by July 1, 2021, to establish the following:

- Methodology the plan will use to determine the qualifying payment amount differentiating by individual market, large group market and small group market
- Any information the plan must share with the out-of-network facility or provider when determining the payment amount
- Geographic regions, taking into account access to items and services in rural and underserved areas, including health professional shortage areas
- Process to receive complaints of violations of the requirements.

HHS can consider other factors, such as payment adjustments for quality or type of facility, and may consult with the National Association of Insurance Commissioners on establishing geographic regions.

In consultation with the Departments of Labor and Treasury, HHS also must issue regulations by October 1, 2021, to establish an audit process to ensure that plans are applying the qualifying payment amount for emergency services. Beginning in 2022, the Secretary will also conduct an audit of no more than 25 health plans, or any plan for which the Secretary has received a complaint or information regarding emergency coverage. The Secretary will submit a report to Congress annually on its audit findings.

Non-Emergency Situations

The CAA generally prohibits balance billing for non-emergency services performed by out-of-network providers at in-network facilities starting January 1, 2022. The non-emergency provisions allow for some exceptions to the surprise billing protections if the patient receives specific notice and provides consent (described below). If the notice and consent requirements are not met, the cost sharing for the item or service cannot be greater than if the service was provided in-network. The cost sharing amount is calculated based on the recognized amount. The recognized amount is the same as described above.

The plan has 30 days to send the provider an initial payment or notice of denial of payment.

Air Ambulances

The law also addresses balancing billing for patients for air ambulance services (the legislation does not address ground ambulance services). If an insured patient receives air ambulance services by an out-of-network provider, and those services otherwise would have been covered if the air ambulance was in-network, the patient may only be

responsible for the same cost sharing that would apply if the provider was in-network. The cost sharing amounts can count toward the patient's in-network deductible and out-of-network maximums.

The plan must to send a payment or notice of denial of payment to the provider within 30 days of the receiving the initial bill from the provider.

Exceptions

Notice and Consent

In the case of non-emergency services, the law lays out specific notice and consent requirements that, if met, permit balancing billing. This exception does not apply to certain ancillary services, described below.

Providers who are eligible to request a consent waiver must include a written notice to the patient not later than 72 hours before the date on which the items or services are provided. This notice must include the following information:

- Notification that the provider or facility is out-of-network
- Clear statement that consent is optional and the patient can seek care from an in-network provider
- Good faith estimate of the amount the patient may be charged
- If the service is to be furnished by an out-of-network provider in an in-network facility, a list of in-network providers who are able to provide the service
- Information on whether prior authorization is needed.

Once the patient receives the notice, she has the option to consent. The notice must be signed by the patient where the patient acknowledges that he was provided with written notice and informed about the payment and how it may affect cost-sharing. The consent must include the date on which the patient received the notice and the date on which the patient signed the consent. The plan must retain the consent for seven years.

HHS, in consultation with the Departments of Labor and Treasury, is tasked with issuing guidance by July 1, 2021, on the format and details of the notice and consent requirements.

Ancillary Services

If the out-of-network provider meets certain notice and consent requirements, the patient may be balanced billed. This opportunity is not available for specified ancillary services.

Ancillary services that may not balance bill include the following:

- Services provided at an in-network facility related to emergency medicine, anesthesiology, pathology, radiology, laboratory and neonatology, regardless of whether they are provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists and intensivists
- Diagnostic services (including radiology and laboratory services)
- Items and services provided by a nonparticipating provider if there is no participating provider who can furnish such item or service at the facility

- Other items and services provided by other specialty practitioners as HHS specifies through rulemaking.

HHS may, through rulemaking, establish and periodically update a list of advanced diagnostic laboratory tests that would not be subject to this prohibition and thus would be eligible for the balance billing notice and consent exception. Medicare regulations define advanced diagnostic laboratory tests at 42 CFR § 414.502, and so HHS may use that definition and the list of defined tests if it pursues this exception.

Independent Dispute Resolution Process

To settle payment disputes between providers and plans, the law uses an arbitration process, known as independent dispute resolution (IDR), for disputed emergency or non-emergency services that fall under the surprise billing prohibitions. This process must be initiated within 30 days of the provider receiving an initial payment or notice of denial of payment from the plan. The provider and plan then have up to 30 days for open negotiation. During this period, the provider and plan can attempt to come to agreement without formally initiating the IDR process. The provider and plan do not have to use all 30 days if either party wishes to go to arbitration.

The provider or plan have four days after the end of the 30-day period to initiate the IDR process. The initiating party must notify the other party and HHS. The parties can continue to negotiate after one party initiates the IDR process.

Providers and plans can consolidate (or batch) similar items and services in the IDR process. However, payment for the items and services must be made by the same plan, and the items and services must be furnished by the same provider or facility, be related to the treatment of a similar condition and be furnished within a 30-day window. HHS has discretion to determine an alternative window for use in limited situations.

The law requires HHS (in consultation with the Departments of Labor and Treasury) to issue regulations detailing the IDR resolution process and required documentation within one year of enactment, or December 27, 2021.

For each calendar quarter beginning in 2022, HHS must publish specified performance metrics on the IDR process.

IDR Entities

The law requires HHS, in consultation with the Departments of Labor and Treasury, to establish a process to certify and recertify IDR entities. Entities must have medical, legal or other expertise to make the required determinations. Entities may not be a health plan or provider, or affiliated with plans or providers. The certification period lasts for five years. While the law does not speak to the ideal number of certified IDR entities, it does state that the process should allow for a sufficient number of entities. HHS may issue other requirements.

HHS is also tasked with providing a method by which the parties involved in the arbitration can choose from the available certified IDR entities. The parties have three days to choose. If no agreement is made, HHS will choose the IDR entity within six days.

Payment Determination

Once the IDR entity is chosen, the arbiter has 30 days to issue a payment determination. Within 10 days of the IDR entity selection, the two parties must submit a payment offer and other information requested by the IDR entity. The IDR entity has flexibility to consider other factors, such as the following:

- Similar payment amounts in the same geographic region (which will be defined by HHS)

- The training level, experience, quality and outcomes measurements of the provider or facility
- The market share held by the out-of-network provider or plan in the geographic region
- The condition and complexity of the care needed
- Teaching status, case mix and scope of services of the out-of-network facility
- Demonstration of good faith efforts by the provider or plan to enter into network agreements, and if available and relevant, contracted rates for the previous four years.

The CAA includes separate factors for IDR entity consideration for air ambulances. These include quality and outcomes measurements of the provider that furnished such services; acuity of the individual receiving such services or the complexity of services; training, experience and quality of the medical personnel; ambulance vehicle type; population density of the pick-up location; and demonstrations of good faith efforts (or lack of good faith efforts) by the nonparticipating provider or facility, or the plan or issuer, to enter into network agreements and, if applicable, contracted rates between the provider and the plan or issuer, as applicable, during the previous four plan years.

The IDR entity may *not* consider such factors as usual and customary charges or the payment amount for the same item or service by a public payor, such as Medicare or Medicaid.

The final payment amount must be one of the amounts submitted by either party. Once the payment determination is made, it is final and binding, and is not subject to further judicial review, except in specific circumstances. The party that initially submitted the request for the IDR process may not initiate another IDR process with the same party for the same item or service for a 90-day period. The final payment must be made within 30 days of the final determination.

HHS has discretion to modify any of these deadlines under extenuating circumstances (which HHS also can define), with the exception of the date required to establish the IDR process (one year from enactment) and the 30-day deadline for final payment.

Within two years of enactment, HHS (in consultation with Departments of Labor and Treasury) will issue a report examining plans' pattern or practice of routine denial, low payment or down-coding of claims, or other abuse of the 90-day period.

Cost of IDR Process

The party whose offer is not chosen must pay all fees charged by the IDR entity. If the parties reach an agreement independently, but within the IDR process period, the IDR fees will be split between the parties.

In addition to the cost of the IDR entity, HHS may prescribe fees for parties that participate in the IDR process to offset expenditures by HHS in carrying out the IDR process.

Patient Protections

The CAA allows for some flexibilities for patients when choosing certain providers:

- If a plan requires the patient to identify a primary care provider, the patient can choose any participating primary care provider.

- If a plan requires the patient to identify a pediatric primary care provider, the patient can choose any in-network physician (including allopathic or osteopathic) who specializes in pediatrics.
- A plan cannot require a referral or authorization for women who seek obstetrical or gynecological care from an in-network provider who specializes in obstetrics or gynecology.

These requirements are in effect for plan years on or after January 1, 2022.

Beginning January 1, 2022, providers also will be required to make a one-page notice available to insured patients with information regarding surprise billing prohibitions, including state requirements, as well as contact information for state and federal entities to report surprise billing violations.

Plans will also be required to include deductible information, out-of-pocket maximum limitations and customer assistance information on electronic or physical beneficiary insurance cards.

Treatment of Uninsured

The law establishes a separate provider-patient dispute resolution process for uninsured individuals. The patient must have been billed "substantially in excess of" a good faith estimate of the expected charges from a provider or plan. Similar to the arbitration process for insured patients, HHS is tasked with establishing a process for certifying IDR entities and a method for selecting a certified IDR entity. These entities are tasked with determining a payment amount. There are similar administrative fees that must be established by HHS. This section, however, is not as prescriptive as the other provisions, and there are no timeframes associated with a resolution process. HHS is required to issue regulations by January 1, 2022, on all of these elements.

Enforcement

Both states and HHS are permitted to enforce provisions of the law. Violations are subject to civil money penalties up to $10,000. HHS has the ability to establish a hardship exemption for these penalties and waive the penalties for providers and facilities that did not knowingly violate the requirements laid out in the law.

Interaction with State Laws

Several states have already enacted comprehensive surprise billing laws. The new federal law defers to existing state requirements with respect to state-established payment amounts, meaning that the CAA does not fully preempt or otherwise displace state payment standards.

States also can continue to pass surprise billing laws and regulations in the future.

Definitions

The new law defines many terms relevant to implementation and compliance. Following are general definitions of key terms in the law. Please refer to the law itself for a specific understanding of defined terms.

Air ambulance services: medical transport by helicopter or airplane for patients

Ancillary services: items and services provided at an in-network facility that are related to emergency medicine, anesthesiology, pathology, radiology, laboratory and neonatology, whether or not provided by a physician or non-physician practitioner, and items and services provided by assistant surgeons, hospitalists and intensivists; diagnostic services (including radiology and laboratory services); items and services provided by a nonparticipating provider if

there is no participating provider who can furnish such item or service at such facility; and other items and services provided by such other specialty practitioners, as HHS specifies through rulemaking

Cost-sharing: includes copayments, coinsurance and deductibles

Emergency department of a hospital: includes a hospital outpatient department that provides emergency services

Emergency medical condition: a medical condition with 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 immediate harm to the patient or serious impairment

Emergency services: includes a medical screening examination and ancillary services routinely available to the emergency department to evaluate emergency medical conditions, as well as other necessary treatment to stabilize the patient

Notably, emergency services can also include items and services provided to patients after they are stabilized and as part of outpatient observation or an inpatient or outpatient stay that is connected to the original emergency visit, unless certain conditions are met. These conditions include the patient's ability to travel using non-medical transportation, and whether the provider gives notice and the patient is in a condition to provide consent. The Secretary is able to specify other conditions, such as coordination of care transitions.

Health care facility: a hospital, hospital outpatient department, critical access hospital, ambulatory surgical center or any other facility specified by HHS

Independent freestanding emergency department: a health care facility that is geographically separate and licensed separately from a hospital and provides emergency services (as defined above)

Nonparticipating emergency facility: an emergency department of a hospital or an independent freestanding emergency department of a hospital that does not have a direct or indirect contractual relationship with a health plan

Nonparticipating health care facility: a health care facility that does not have a direct or indirect contractual relationship with a health plan

Nonparticipating provider: a physician or other health care provider, acting within licensed scope of practice, who does not have a contractual relationship with a health plan

Out-of-network rate: an item or service furnished to patients by a nonparticipating provider or nonparticipating emergency facility. The amount is either specified through state law or an All-Payer Model or, if not specific by the state, the amount of agreed upon through open negotiation as described above or the amount determined by the IDR

Participating emergency facility: an emergency department of a hospital or an independent freestanding emergency department of a hospital that has a direct or indirect contractual relationship with a health plan

Participating health care facility: a health care facility with a direct or indirect contractual relationship with a health plan

Participating provider: a physician or other health care provider, acting within licensed scope of practice, who has a contractual relationship with a health plan

Qualifying payment amount: for items and services furnished in 2022, the median contracted rates recognized by the plan as the total maximum payment provided on January 31, 2019, for the same or similar item or service, by a similar provider, in the same geographic region. This amount is increased by the consumer price index annually. If a plan did not offer coverage in 2019 in a specific geographic region, the Secretary can determine the methodology for the rate for the first year. For subsequent years, the qualifying payment methodology applies.

Recognized amount: for items or services furnished by a nonparticipating provider or nonparticipating emergency facility:

- Applicable state laws would apply, including if agreements exist under an All Payer Model.
- If no state law exists, the qualifying payment amount would apply (see definition above).

Visit: includes equipment and devices, telemedicine services, imaging services, laboratory services, preoperative and postoperative services, and other items and services as HHS may specify, regardless of whether the provider furnishing such items or services is at the facility

Conclusion

The inclusion of surprise billing provisions in CAA means that opportunities for advocacy have shifted from Congress to the Administration. The surprise billing law has drawn both criticism and praise, with providers, plans and patient groups sometimes advocating for differing positions. With the details of many important policies subject to agency rulemaking, stakeholders should be prepared to advocate for favorable definitions, processes and timeframes.