Wynne Health Group

Issue Brief *February 10, 2021*

NO SURPRISES ACT SUMMARY AND IMPLEMENTATION

EXECUTIVE SUMMARY

The Consolidated Appropriations Act, 2021 (P.L. 116-260), signed into law by President Donald Trump on December 27, 2020, included the No Surprises Act – a comprehensive package aimed at protecting patients from surprise medical bills.[i] Patient protections, along with new coverage requirements and balance billing prohibitions, go into effect on January 1, 2022. With implementation underway, the Wynne Health Group prepared this issue brief to provide a roadmap for anticipated rulemaking by the Departments of Health and Human Services (HHS), Labor, and Treasury and oversight activity in 2021 and beyond (see red boxes). We also delineate new requirements for providers and facilities (see blue boxes) as well as insurers (see grey boxes).

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I. SURPRISE MEDICAL BILLING

A. SCOPE OF PROTECTIONS[ii]

Patient cost-sharing protections, surprise billing coverage requirements, and balance billing prohibitions will apply to individual and group health plans, including fully insured plans sold through the individual and group markets, self-funded plans (i.e., ERISA) plans, federal employee health benefit plans, and grandfathered health plans for the following services:

- **Emergency services** furnished by an out-of-network hospital or freestanding emergency department, or an out-of-network provider at an in-network facility and **including post-stabilization services unless the following conditions are met**:
    - The provider or facility determines the individual is able to travel using nonmedical transportation or nonemergency medical transportation
    - The provider satisfies the notice and consent requirements (described in more detail below)
    - The individual is in a condition (determined in accordance with guidelines established through HHS rulemaking) to provide informed consent
    - Other conditions (specified through HHS rulemaking) are satisfied, such as coordinating care transitions with in-network providers and facilities

- **Non-emergency ancillary services** furnished by an out-of-network provider at an in-network facility, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; diagnostic services (e.g., radiology and laboratory services); and additional items and services specified through HHS rulemaking.

  HHS is permitted to establish, through rulemaking, and periodically update a list of "advanced diagnostic laboratory tests" that will not be categorized as an ancillary service. Therefore, these selected services would not be subject to the coverage requirements and balance billing prohibitions. HHS could potentially use the list of advanced diagnostic laboratory tests established in the Clinical Laboratory Fee Schedule. If HHS applies Medicare's definition for "advance diagnostic laboratory tests," then HHS may exempt advanced diagnostic laboratory tests established in the Clinical Laboratory Fee Schedule.[iii]

- **Other non-emergency services** furnished by an out-of-network provider or out-of-network facility **if notice and consent requirements are not met.**

- **Air ambulance services.**

B. COST-SHARING REQUIREMENT[iv]

The cost-sharing requirement for out-of-network services is calculated using the "recognized amount," which is: (1) the amount required by a state surprise medical billing law; (2) the amount established through an All-Payer Model Agreement; or (3) the "qualifying payment amount" (which is likely applicable in most situations). The qualifying payment amount is also considered during the independent dispute resolution process (discussed in more detail below).

Specifically, the qualifying payment amount is the median contracted in-network rate (including the cost-sharing amount and amount to be paid by the insurer) on January 31, 2019 for the same or a similar item or service provided in the same geographic region, adjusted for inflation as follows:

- For calendar year (CY) 2022, the initial qualifying payment amount is increased by the percentage increase in the consumer price index for all urban consumers (CPI-U) over 2019, over 2020, and over 2021.
- For CY 2023 and subsequent years, the CY 2022 qualifying payment amount is increased by the percentage increase in the CPI-U over the previous year.

HHS Rulemaking – HHS, in consultation with Labor and Treasury, must establish the methodology for insurers to determine the "qualifying payment amount," differentiating by large group market and small group market by **July 1, 2021.** The rule must also include:

- Information that the insurer will share with the out-of-network provider or facility when determining the qualifying payment amount
- Geographic regions to determine the qualifying payment amount (incorporating input from the National Association of Insurance Commissioners)
- Process to receive complaints from individuals regarding alleged violations of insurer requirements for audit use

C. COVERAGE REQUIREMENTS[v]

Insurer Requirement – Insurers must cover out-of-network services (within the scope of the No Surprises Act) as if they were furnished in-network – specifically:

- No prior authorization requirement or any limitation that is more restrictive than requirements that would apply to in-network services
- Cost-sharing requirement cannot exceed the cost-sharing amount that would apply for in-network services
- Cost-sharing requirement is calculated based on the recognized amount (which is the qualifying payment amount (i.e., median contracted rate) or amount specified by a state surprise billing law or an All-Payer Model Agreement)
- Cost-sharing requirement must count towards the patient's in-network deductible or out-of-pocket maximum

- An initial payment or a notice of denial of payment must be sent to the provider or facility within 30 calendar days of receiving the bill
- A follow-up payment must be sent to the provider or facility, if applicable, in accordance with the timing requirements of open negotiations, independent dispute resolution, a state surprise billing law, or an All-Payer Model Agreement
- An in-network pediatrician must be able to be designated as a child's primary care provider
- Patients must have access to obstetrical and gynecological care without having to go through an insurer's authorization or referral process

Oversight – HHS will conduct audits to ensure group plans are charging a cost-sharing amount based on the qualifying payment amount. Each year, the agency is authorized to audit claims data from up to 25 plans each year. In addition, HHS is permitted to audit plans if it has received any complaint or information regarding noncompliance. Audits do not apply to insurers that are required to pay an amount that is determined by a state's surprise billing law or an All-Payer Model Agreement. Audits will presumably begin in 2022.

Rulemaking – HHS, in consultation with Labor and Treasury, must establish the audit process by **October 1, 2021**.

Report to Congress – HHS must submit an annual report on the number of insurers that were audited that year, beginning CY 2022.

D. BALANCE BILLING PROHIBITIONS[vi]

Provider and Facility Requirement – An out-of-network provider at an in-network facility or an out-of-network facility (within the scope of the No Surprises Act) is prohibited from holding patients liable for a cost-sharing amount that exceeds the cost-sharing amount that would have been charged if the service was furnished in-network.

State Enforcement – Each State is authorized to enforce provider and facility requirements. However, the federal government will play a role in enforcement if "a State has failed to substantially enforce the requirements." A State may notify Labor, HHS, and Treasury about violations and any enforcement actions. The No Surprises Act does not preempt state enforcement of state surprise billing laws if those state surprise billing laws provide, at a minimum, the same level of patient protections as the No Surprises Act.

HHS Enforcement – HHS is authorized to issue civil monetary penalties up to $10,000 per violation. HHS may waive a penalty if a facility or a provider: (1) unknowingly violates the requirements and could not have reasonably known in advance; (2) withdraws the bill within 30 days of the violation; and (3) reimburses the patient with interest (at an interest rate determined by HHS). HHS is also authorized to establish a "hardship exemption" to the penalties.

HHS Rulemaking – HHS must establish a process by **January 1, 2022** to receive complaints of violations and to respond to such complaints within 60 days of receipt.

Labor Investigations – Labor is required to identify patterns of violations of provider and facility requirements involving patients enrolled in group health plans or group health insurance coverage offered by a health insurance issuer.

Labor Rulemaking – Labor must establish a process by **January 1, 2022** to receive complaints of violations of provider and facility requirements involving patients enrolled group health plans or group

health insurance coverage offered by a health insurance issuer and to transmit complaints to States or HHS (as appropriate) for potential enforcement actions.

E. Notice and Consent Requirements[vii]

Provider and Facility Requirement – A provider or facility is permitted to balance bill for eligible items and services (i.e., non-emergency, non-ancillary services) if they meet the notice and consent requirements: (1) **notify the patient,** in writing, of their out-network status and the option to seek care from an in-network provider or facility 72 hours before the appointment; and (2) **obtain consent** before items or services are furnished. If an appointment is scheduled within 72 hours of when such items or services are furnished, then notice must be provided when the appointment is made.

The **written notice** must contain the following information:

- Network status of the provider or facility
- Good faith estimate of the items and services (non-binding)
- For an in-network facility and out-of-network provider, a list of in-network providers at that facility who can furnish the items or services
- Information about whether prior authorization or other care management limitations may be required

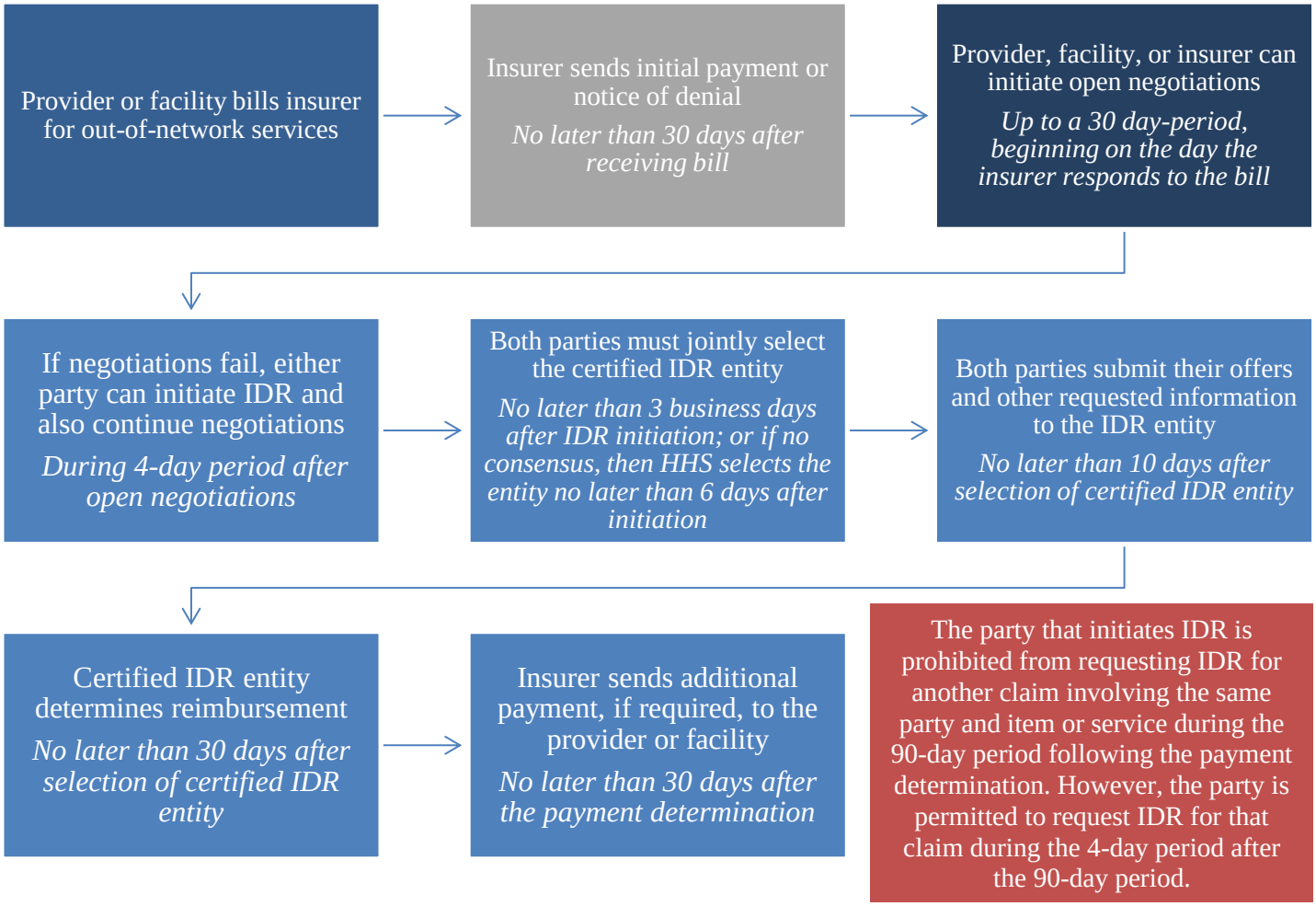
In the **signed consent form**, the patient must acknowledge receipt of written notice and that subsequent cost-sharing may not count towards meeting their deductible or out-of-pocket maximum or. Facilities must retain notice and consent documentation or at least a seven-year period after the appointment.

HHS Guidance – HHS must issue guidance on the notice and consent requirements for out-of-network providers and facilities by **July 1, 2021**.

F. Settling Payment Disputes[viii]

In a state without a surprise medical billing law or an All-Payer Model Agreement, a provider, facility, or insurer will use the following process to determine reimbursement for out-of-network services – open negotiations followed by independent dispute resolution (IDR), if necessary. The amount determined by the certified IDR entity is binding.

Figure 1. Payment Determination Process



The certified IDR entity is prohibited from considering usual and customary charges, billed charges, or the rates paid by federal health care programs (e.g., Medicare, Medicaid, TRICARE). The following factors must be considered in the payment determination:

- Qualifying payment amount for comparable items or services that are furnished in the same geographic region
- Level of training, experience, and quality and outcomes measurements (such as those endorsed by the National Quality Forum) of the provider or facility
- Market share held by the provider or facility or by the insurer in the geographic region where the item or service was furnished
- Patient acuity or complexity of item or service
- Teaching status, case mix, and scope of services furnished by the facility

- Demonstration of good faith efforts made by the provider or facility or by the insurer to enter into network agreements, and if applicable, the contracted rates between the provider or facility and the insurer during the previous four years

The IDR process for air ambulance services generally follows the same process outlined for other items and services. The main difference is that the certified IDR entity must also consider the ambulance vehicle type, including the clinical capability of the vehicle, and the population density of the pick up location (e.g., urban, suburban, rural, or frontier).

HHS, Labor, and Treasury Rulemaking – HHS, Labor, and Treasury must establish the IDR process, including the criteria to batch similar items and services in a single payment determinations and processes concerning IDR entities (e.g., certification, selection) by **December 27, 2021**.
HHS, Labor, and Treasury Rulemaking – HHS, Labor, and Treasury must establish the IDR process for air ambulance services by **December 27, 2021**.
HHS Publication – Certified IDR entities are required to submit to HHS information that they receive from both parties. HHS must publish certain information on the IDR process on a quarterly basis. • Number of IDR requests, size of provider practices submitting requests, subsequent number of payment determinations, and length of time to make determinations • Number of times the amount determined through IDR or negotiations exceeds the qualifying payment amount • Description of items and services, including geography and the practice specialty of the provider furnishing that item or service • Offers from both parties and the selected offers, expressed as a percentage of the qualifying payment amount • Identity of the insurer, provider, or facility that make IDR requests • IDR costs, including HHS spending, fees, and IDR entity compensation

G. IDR Entity Certification and Compensation[ix]

IDR entities must meet eligibility criteria delineated in the No Surprises Act and be certified via the process established by HHS, Labor, and Treasury through rulemaking. This process must ensure that a sufficient number of entities is available to make payment determinations in a timely manner. Entities cannot be an insurer, provider, or facility (or affiliated with one), and they must have relevant medical and legal expertise and meet fiscal integrity and confidentiality requirements.

A certification lasts for a five-year period and may be revoked for noncompliance with requirements. Patients, providers, facilities, and insurers may petition for the denial of a certification or the revocation of a certification if the entity fails to meet its requirements.

The party responsible for compensating a certified IDR entity for their services will depend on how a payment dispute is settled. If the certified IDR entity makes a payment determination, then the party whose

offer is not chosen (i.e., losing party) must pay all the fees charged by the entity. If parties reach a settlement before a payment determination is made, then the parties will split the fees.

II. Additional Requirements to Prevent Surprise Medical Bills

The No Surprises Act establishes new requirements for insurers as well as providers and facilities that are aimed at preventing surprise medical bills. Overall, the requirements are designed to increase transparency and provide patients with additional coverage and cost information to avoid receiving a surprise medical bill. These requirements will take effect on January 1, 2022. In addition, the No Surprises Act requires HHS to implement protections against provider discrimination.

A. Price Comparison Tool[x]

Insurer Requirement – Insurers must maintain online price comparison tools and provide comparisons over the phone to allow patients to compare expected cost-sharing for items and services across multiple in-network providers.

B. Transparency on Out-of-Network Costs[xi]

Insurer Requirement – Insurers must include new information on any physical or electronic insurance identification card:

- All plan deductibles, including in-network and out-of-network deductibles, as applicable
- Maximum limits on out-of-pocket costs, including in-network and out-of-network out-of-pocket cost limits, as applicable
- Telephone number and website with consumer assistance information, such as network status of hospitals and urgent care facilities

C. Disclosure on Patient Protections Against Balance Billing[xii]

Insurer Requirement – Insurers must make information available on their websites and in each explanation of benefits (as applicable) regarding patient protections against balance billing, insurer requirements relating to cost-sharing, and appropriate federal and state contact information for patients to report any violations. If required by state law, the insurer must also provide information on allowable charges for out-of-network services and any applicable cost-sharing requirements.

D. Advance Notice of Expected Out-of-Pocket Costs and Coverage[xiii]

Provider and Facility Requirement – Providers and facilities must ask a patient for their health insurance coverage status and provide a "good faith estimate" of the total expected charges for the scheduled items and services, including their expected billing and diagnostic codes, to the insurer (if insured) or the patient (if uninsured). The notice must also include a good faith estimate of any items or

services reasonably expected to be provided in conjunction with the scheduled item or service or any items or services reasonably expected to be provided by another provider or facility.

The notice must be provided to the insurer or uninsured patient at least three days before the service is furnished and no later than one business day after the appointment is scheduled. If the appointment was scheduled at least 10 business days before the service, then the notice must be provided within three business days of a patient requesting the estimate or scheduling the appointment.

HHS Rulemaking – HHS must establish a "patient-provider dispute resolution" that allows an uninsured patient to appeal a billed charge that is "substantially in excess" of the good faith estimate and seek a new cost determination from a certified IDR entity by **January 1, 2022**. HHS must also establish an administrative fee for participating in the patient-provider dispute resolution process that will not create a barrier for uninsured individuals.

Insurer Requirement – Insurers must provide patients with an "Advanced Explanation of Benefits" (EOB) prior to an appointment or upon request. The provider or facility sending the required "good faith estimate" triggers this Advance EOB requirement. The notice must include:

- Network status of the provider or facility
    - If the provider or facility is in-network, then the insurer must also provide the contracted rate for the item or service based on the billing and diagnostic codes submitted by the provider or facility.
    - If the provider or facility is out-of-network, then a description of how the patient may obtain information on in-network providers and facilities.
- Good faith estimate of the insurer's payment obligation
- Good faith estimate of the cost-sharing requirement
- Good faith estimate of the amount that the patient has incurred toward their financial responsibility limits (such as deductibles and out-of-pocket maximums)
- A disclaimer that the item or service is subject to a medical management, as applicable
- A disclaimer that all information provided in the notice is an estimate based on the items and services reasonably expected, at the time that the appointment was scheduled (or information was requested), to be furnished and is subject to change
- Other information deemed appropriate by the insurer to include

The notice must be provided to patients (by mail or electronically, per patient preference) no later than one business day after the date on which the insurer receives a notification from the provider or facility about the scheduled appointment or a request from the patient. If the appointment was scheduled at least 10 business days before the service, then the notice must be provided within three business days of receiving the notification or request.

HHS is authorized to modify the timing requirements for items or services that have low utilization or significant variation in costs.

E. PROVIDER DIRECTORY[xiv]

Insurer Requirement – Insurers must establish processes to ensure accuracy of provider directories and timely sharing of such information with patients. If the insurer provides inaccurate information about the network status of providers (via provider directories or other communications) or does not respond to a patient's request for such information, then insurers are required to hold patients responsible for the in-network cost-sharing requirement. The insurer must also count the cost-sharing requirement towards the patient's deductible or out-of-pocket maximum. This requirement does not preempt existing state law.

Specifically, insurers must:

- Establish a verification process to ensure accuracy of provider directories at least once every 90 days (remove unverifiable information, update the directory within two business days of receiving information from a provider or facility)
- Establish a protocol for the insurer to respond, upon request for information from a patient via telephone, e-mail, or electronic, web-based, or Internet-based means, about the network status of a provider or facility. Insurers must respond no later than one business day after the request and retain a record of the communications for at least two years following their response
- Maintain a web-based provider directory that includes a list of each provider or facility that has a contractual relationship with the insurer, their contact information, and their specialty

Provider and Facility Requirement – Providers and facilities must have a process to ensure timely provision of provider directory information to insurers, at a minimum:

- When the provider or facility begins a network agreement with an insurer
- When the provider or facility terminates a network agreement with an insurer
- When there are material changes to provider directory content
- Any other time (including upon request by the insurer) determined appropriated by the provider, facility, or the HHS Secretary

If a provider or facility submits a bill to a patient based on inaccurate cost-sharing information and the patient pays the bill, then the provider is required to reimburse the patient for the full amount in excess of the in-network cost-sharing amount for the item or service, plus interest (at a rate determined by the HHS Secretary).[xv]

F. CONTINUITY OF CARE[xvi]

Insurer Requirement – Insurers must notify "continuing care patients" on a "timely basis" about changes in network status of their providers and facility and continue to cover their care at in-network cost-sharing rate (if elected by the patient) for up to a 90-day period beginning on the day the notice is provided. A continuing care patient is an individual who is undergoing treatment for a serious and complex condition; undergoing institutional or inpatient care; scheduled to undergo nonelective surgery, including postoperative care; pregnant and undergoing treatment for the pregnancy; or terminally ill.

Provider and Facility Requirement – Providers and facilities must accept payment from an insurer (after their contractual relationship is terminated) for items and services furnished to a continuing care patient during the 90-day period.

G. External Review Process for Adverse Determinations[xvii]

Insurer Requirement – Insurers must comply with the applicable external review process (state or federal), upon a patient's request, to determine whether a surprise medical bill was allowed or whether surprise billing protections were applicable. This external review process must meet or exceed the consumer protections in the National Association of Insurance Commissioners Uniform External Review Model Act.

H. Provider Non-Discrimination[xviii]

Insurer Requirement – Insurers are prohibited from discriminating against a provider who is acting within the scope of their license or certification from participating in their network.[xix] Insurers are not required to accept all types of providers into their network. Insurers are also allowed to establish varying reimbursement rates based on quality or performance measures. This provider discrimination prohibition was initially established in the Affordable Care Act and is currently implemented through sub-regulatory guidance.

HHS Rulemaking – HHS must issue a proposed rule (with a 60-day comment period) to implement this provision by **January 1, 2022** and issue a final rule no later than six months after the end of the comment period.

III. State All-Payer Claims Database[xx]

The No Surprises Act creates a new grant program to support states establish or improve State All Payer Claims Databases. Funding will be awarded over a three-year period ($1 million for fiscal years 2022 and 2023, and $2.5 million for fiscal year 2024). HHS is authorized to prioritize multi-state applications and applications that will implement the standardized reporting format for self-insured group health plans (established through rulemaking).

Entities, including health care providers and insurers, are permitted to request access to the State All-Payer Claims Databases (funded by this new grant program) for the purposes of research or for quality improvement or cost-containment. Employers and employer organizations may request customized reports from a State All Payer Claims Database (funded by this new grant program), at cost. Authorized users will have access to aggregate data sets (i.e., non-customized reports), free of charge.

HHS Guidance – HHS must establish (and periodically update) a standardized reporting format for group health plans to voluntarily report data to State All Payer Claims Database by **December 27, 2021**. Data includes medical claims, pharmacy claims, dental claims, and eligibility and provider files that are collected from private and public payers. HHS must also issue guidance on the process for States to collect this data in the standardized reporting format by **December 27, 2021.**

HHS Advisory Committee – HHS must convene an Advisory Committee by **March 27, 2021** to advise HHS format and guidance of the standardized reporting format. The Advisory Committee must include representatives from various government agencies, a representative of a State All-Payer Claims Databases, and members appointed by the Comptroller General including:

- A representative of an employer that sponsors a group health plan
- A representative of an employee organization that sponsors a group health plan
- An academic researcher with expertise in health economics or health services research
- One consumer advocate
- Two additional members

The Advisory Committee must submit a report with recommendations on the format and guidance to HHS and select congressional committees by **June 25, 2021**. The Advisory Committee sunsets on the date that the report is submitted.

IV. AMBULANCE-RELATED ISSUES

The No Surprises Act protects patients against surprise medical bills arising from air ambulance services but not ground ambulance services. However, the mandatory establishment of new advisory committee tasked with examining balance billing issues among ground ambulance services signals possible policymaking on this issue in the future. In addition, new reporting requirements for providers and insurers regarding air ambulance services as well as the establishment of new advisory committee charged with recommending quality, patient safety, and clinical capability standards for air ambulance services may inform future policy changes.

A. AIR AMBULANCE SERVICES[xxi]

Air Ambulance Provider Requirement – Air ambulance providers must submit to HHS and Transportation a report on air ambulance service providers that contains:

- Cost data
- Number and location of all air ambulance bases operated by the provider
- Number and type of aircraft operated by the provider
- Number of air ambulance transports (disaggregated by payor mix)
- Number of claims denied by insurers, number of emergency and nonemergency air transports (disaggregated by air ambulance base and type of aircraft)
- Other information specified by HHS

The report is due no later than 90 days within implementation of the final rule on reporting requirements for air ambulance services.

Insurer Requirements – Insurers must submit to HHS, Labor, and Treasury a report that contains claims data for air ambulance services furnished by providers, disaggregated by each of the following factors:

- Circumstances of the services (i.e., emergency or non-emergency)
- Type of owner or sponsor (e.g., hospital, municipality, independent)
- Pick-up location (i.e., rural or urban area)
- Type of aircraft
- Network status

The report is due no later than 90 days within implementation of the final rule on reporting requirements for air ambulance services.

HHS Rulemaking – HHS, in consultation with the Department of Transportation, must establish the form and manner in which air ambulance providers and insurers will submit the required information by **December 27, 2021**.

HHS Report – HHS, in consultation with Transportation, must develop and make publicly available a report that summarizes the information submitted by air ambulance providers and insurers:

- Percentage of air ambulance providers by type of owner or sponsor
- Assessment of competition among air ambulance providers
- Assessment of the average charges for air ambulance services, among paid by insurers, and out-of-pocket by consumers
- Assessment of air ambulance capability in rural and urban areas
- Evidence of gaps in rural access to air ambulance services
- Percentage of air ambulance services that have contracts with insurers
- Assessment of whether there are instances of unfair, deceptive, or predatory practices by air ambulance providers of air ambulance services in collecting payments
- Assessment of whether there are instances of non-competitive behavior among air ambulance
- Assessment of the frequency of patient balance billing, patient referrals to collections, and other activity involving collections
- Assessment of the frequency of claims appeals made by air ambulance providers to insurers
- Other related cost, quality, or other data

The report is due no later than one year after the due date for air ambulance provider and insurer reporting requirements.

HHS Enforcement – HHS is authorized to issue civil monetary penalties to air ambulance providers up to $10,000 for noncompliance with reporting requirements. HHS may waive a penalty if the provider submits incomplete information but demonstrates good faith efforts to submit missing information.

Transportation Oversight – Transportation is permitted to use the information submitted by air ambulance providers to determine whether a provider has engaged in unfair and deceptive practices and unfair methods of competition.

HHS and Transportation Advisory Committee – HHS and Transportation must establish an Advisory Committee on Air Ambulance Quality and Patient Safety by **February 25, 2021** that will make recommendations on quality, patient safety, and clinical capability standards for each clinical capability level of air ambulances. The Advisory Committee must meet by **March 27, 2021** and issue a report to Congress (and make publicly available) no later than **September 23, 2021**.

The Advisory Committee must include representatives from government agencies, three representatives of the air ambulance industry (appointed by Transportation), and one representative (appointed by HHS) of each of the following:

- State health insurance regulators
- Health care providers
- Health insurers
- Patient advocacy groups
- Accrediting bodies with experience in quality measure

B. GROUND AMBULANCE SERVICES[xxii]

HHS, Labor, and Treasury Advisory Committee – HHS, Labor, and Treasury must establish an Advisory Committee on Ground Ambulance and Patient Billing by **March 27, 2021** to make recommendations on 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 report is due no later than 180 days after the first meeting.

The Advisory Committee must include representatives from government agencies, three representatives of the ground ambulance industry (jointly appointed), and one representative (jointly appointed) of each of the following:

- State insurance regulators
- Health insurers
- Patient advocacy groups
- Consumer advocacy groups
- State and local governments
- Physicians specializing in emergency, trauma, cardia, or stroke
- State Emergency Medical Services Officials
- Emergency medical technicians, paramedics, and other emergency medical service personnel

V. IMPLEMENTATION TIMELINE

The following timeline highlights due dates for compliance, implementing regulations and guidance, congressionally mandated reports and publications, and advisory committees. The rulemaking process presents opportunities to shape the implementation of the No Surprises Act through public comments, participation in advisory committees, and other advocacy efforts.

The mandatory reports to Congress[xxiii], required publication of information, and other oversight activity is likely to inform future policymaking and administrative actions. Possible topics include:

- Refinements to the processes for settling payment disputes (e.g., factors that must be considered during IDR, restrictions on subsequent requests for IDR)

- Protections against surprise medical bills for ground air ambulance services
- Additional transparency requirements
- Anti-trust enforcement

Table 1. Implementation Timeline

Type	Activity	Responsible Party	Due Date
Advisory Committee	Advisory Committee on Air Ambulance Quality and Patient Safety	HHS, Transportation	Feb. 25, 2021
Advisory Committee	Advisory Committee on State All-Payer Claims Databases	HHS	Mar. 27, 2021
Regulation	Qualifying payment amount (i.e., median in-network contracted rate) methodology	HHS, in consultation with Labor and Treasury	July 1, 2021
Guidance	Notice and consent requirements	HHS	July 1, 2021
Regulation	Audit process on insurer compliance	HHS, in consultation with Labor and Treasury	Oct. 1, 2021
Grant	Funding authorization for State All Payer Claims Database grants	HHS	Oct. 1, 2021 to Sept. 30, 2025
Regulation	Independent dispute resolution process	HHS, Labor, Treasury	Dec. 27, 2021
Regulation	Independent dispute resolution process for air ambulance services	HHS, Labor, Treasury	Dec. 27, 2021
Guidance	Standardized reporting format and guidance for group health plans to voluntary report to State All Payer Claims Databases	HHS	Dec. 27, 2021
Regulation	Rules for air ambulance service reporting requirements for providers and insurers	HHS, Transportation	Dec. 27, 2021
Regulation	Modified Advanced EOB timing requirements for items or services that have low utilization or significant variation in costs	HHS	At HHS discretion
Compliance	Coverage requirements, balancing billing prohibitions, transparency requirements, continuity of care requirements	Providers, facilities, insurers	Jan. 1, 2022 or plan years beginning Jan. 1, 2022
Regulation	Complaint process for provider and facility violations	HHS, Labor	Jan. 1, 2022
Regulation	Patient-provider dispute resolution process	HHS	Jan. 1, 2022
Regulation	Implementation of protections against provider discrimination	HHS, Labor, Treasury	Jan. 1, 2022 (proposed rule due)

			Final rule due six months after 60-day comment period.
Compliance	Air ambulance service reporting requirements	Air ambulance providers, insurers	TBD, within 90 days of final rule
Report	Air ambulance service activity	HHS, DOT	TBD
Report	Number of insurer audits	HHS	2022, annually thereafter
Publication	IDR activity	HHS	Possibly 2022, quarterly thereafter
Report	Patterns of vertical or horizontal integration across the health care industry, overall health care costs, access to health care	HHS, FTC, DOJ	Jan. 1, 2023, annually through 2027
Report	Provider network adequacy	GAO	Jan. 1, 2023
Report	IDR process, financial relationship between providers and facilities that use IDR and private equity investment firms	GAO	Dec. 31, 2023
Report	Impact of the 90-day period suspending subsequent IDR requests, such as payment delays, denials, and down-coding of claims.	HHS, Labor, Treasury	Dec. 27, 2024 (interim report due) Final report due Dec. 27, 2026
Report	Effects of the No Surprises Act on provider networks, fee schedules and amounts for health care services, and contracted rates.	GAO	Jan. 1, 2025

[i] https://www.congress.gov/bill/116th-congress/house-bill/133
[ii] Secs. 102, 104, 105
[iii] https://www.govinfo.gov/content/pkg/CFR-2016-title42-vol3/pdf/CFR-2016-title42-vol3-sec414-502.pdf
[iv] Sec. 102
[v] Sec. 102
[vi] Sec. 104
[vii] Sec. 104
[viii] Sec. 103
[ix] Sec. 103
[x] Sec. 114
[xi] Sec. 107
[xii] Sec. 116

[xiii] Secs. 111 and 112
[xiv] Sec. 116
[xv] Sec. 116
[xvi] Sec. 113
[xvii] Sec. 110
[xviii] Sec. 108
[xix] Sec. 108
[xx] Sec. 115
[xxi] Sec. 106
[xxii] Sec. 117
[xxiii] Sec. 109