AHPA
ADVENTIST HEALTH POLICY ASSOCIATION

H.R. 133: Surprise Billing and Transparency

The Consolidated Appropriations Act of 2021 (H.R. 133) includes several provisions on surprise billing and transparency that are set to take effect on January 1, 2022. Further details on these provisions will be included in rules to be issued by the Department of Health and Human Services (HHS) in the near future.

How does H.R. 133 address surprise billing and transparency?

Below are the key issues covered in the legislation. For states with existing surprise billing and transparency laws, the legislation gives state law precedence, but more guidance is likely to be provided via rulemaking.

Consumer Protections

- **Protects patients from surprise medical bills arising from out-of-network emergency care** (including air ambulance), ancillary services provided by out-of-network providers at in-network facilities, and out-of-network services provided at in-network facilities without the patient's informed consent.
- **Prohibits health providers from balance billing patients beyond the in-network cost-sharing amount**, which will be determined through a formula established by the HHS Secretary in future rulemaking.
- **Requires health providers to post on the facility's public website, a one-page notice outlining the balance billing protections of the legislation, along with any other relevant state law requirements.** Providers must also share the notice with individuals who are "participants, beneficiaries, or enrollees of a group health plan" electronically or by mail as specified by the individual.

Independent Dispute Resolution (IDR) Process

- **Directs the Secretaries of HHS, Labor and Treasury to establish an IDR process through future rulemaking.**
- Provides a 30-day open negotiation period for providers and insurers to settle out-of-network claims. If the parties are unable to reach an agreement, they can engage in the IDR.
- The IDR will be administered by an independent, private entity and there will be no dollar threshold for claims to qualify.

- Providers may batch similar services or those that are part of a bundled payment in one proceeding when claims are from the same payer.
- Payments must be made within 30 days of the date on which an IDR determination is made.
- To determine the reimbursement rate, the arbitrator is required to consider the market-based median in-network rate, alongside other factors, such as patient acuity and the complexity of services.
- The party whose offer was not chosen by the IDR entity, pays the costs of the IDR. Parties that use the IDR process will be required to pay an administrative fee to the Secretary each year. The amount to be established by the Secretary of HHS.

Transparency Requirements

- **Requires providers to inform patients of their network status and provide a "good faith estimate" of charges at least 72 hours before furnishing a scheduled service.** These estimates must be provided also for any ancillary services, along with the expected billing and diagnostic codes. For appointments made within 72 hours of receiving an out-of-network service, the notice must be provided to the patient on the day the appointment is made. If the service is in-network, the provider must share the good faith estimate no later than one day after scheduling the service.
- **Requires HHS to establish a patient-provider dispute resolution process for uninsured individuals by no later than January 1, 2022.** The process would allow uninsured patients to dispute claims that are "substantially in excess" of the good faith estimate. This term may be defined through rulemaking.
- **Requires providers to obtain the patient's written consent prior to furnishing an out-of-network service** and retain that documentation for at least seven years after the service is provided.