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Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services

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SUMMARY

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Surprise Billing in Private Health Insurance: Overview of Federal Consumer Protections and Payment for Out-of-Network Services

The term *surprise billing* typically refers to individuals receiving large, unexpected medical bills for out-of-network care. Generally, surprise billing occurs when consumers are unknowingly, and potentially unavoidably, treated by providers outside of their health insurance plan networks and, as a result, unexpectedly receive larger bills than they would have received if the providers had been in their plan networks. To address surprise billing, Congress passed the No Surprises Act, which was included as part of the Consolidated Appropriations Act, 2021 (P.L. 116-260).

No federal requirements directly addressed surprise billing prior to the passage of the No Surprises Act, but over half of states had implemented policies to address surprise billing in some capacity. However, the state laws are limited in application, as certain types of health insurance plans—such as self-funded plans offered by employers—are exempt from state insurance regulation. Among the states that offer such consumer protections, policies vary in their application and differ according to the types of situations addressed (e.g., emergency services, out-of-network care at an in-network facility); the types of plans addressed (e.g., health maintenance organization [HMO], preferred provider organization [PPO]); and the methods used to determine insurer payments to providers for such services (e.g., benchmark, arbitration).

Beginning in 2022, federal requirements will address surprise billing in eight types of situations: (1) out-of-network emergency services; (2) out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; (3) out-of-network nonemergency, non-ancillary services provided at an in-network facility; (4) out-of-network nonemergency, ancillary services provided at an in-network facility; (5) out-of-network air ambulance services; (6) services scheduled at least three business days in advance; (7) out-of-network services from a provider that initially was in network but subsequently became out of network during the course of treatment (i.e., continuity of care); and (8) out-of-network services from a provider that the consumer assumed was in network based on incorrect information from the plan. In many specified situations, the surprise billing consumer protections and corresponding insurer/provider requirements are structured similarly. However, there are some distinctions with respect to how federal requirements apply to specific surprise billing situations.

Similar to many state laws, federal surprise billing requirements often address the financial relationships among insurers, providers, and consumers. They do so by establishing new requirements on insurers and providers to create a degree of consumer protection related to reducing patient financial responsibilities with respect to some types of out-of-network care and/or by providing consumers with information so they can make an informed decision about whether to receive scheduled out-of-network care.

In addition, federal requirements often specify the methods by which insurers determine payment to providers in certain surprise billing situations (because solely reducing consumer financial liability in such situations would reduce the total amount providers receive for their services). This type of requirement effectively specifies what the insurer and the provider are to recognize as the total payment for specified out-of-network care. For most surprise billing situations in which federal law applies, insurers make an initial payment to providers for services and either entity subsequently may request to open negotiations if the entity is unsatisfied with the initial payment amount. If an agreement cannot be reached through negotiations, an independent dispute resolution process (IDR) is available; the IDR process allows the payment amount to be determined by a neutral third party. In some instances where state surprise billing laws apply, state law methodologies will be used to determine the payment amount instead of this federal methodology.

This report provides an overview of private health insurance billing and describes federal requirements related to surprise billing. **Table A-1** summarizes all deadlines and deliverables required in the No Surprises Act. **Appendix B** summarizes additional provisions of the No Surprises Act not explicitly summarized or referenced elsewhere in the report. **Table C-1** summarizes the applicability of federal surprise billing requirements to different surprise billing situations.

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Surprise Billing

The term *surprise billing* typically refers to an individual receiving a large, unexpected medical bill for out-of-network care. Often surprise billing occurs when a consumer is unknowingly, and potentially unavoidably, treated by a provider outside of the consumer's health insurance plan network and, as a result, unexpectedly receives a larger bill than he or she would have received if the provider had been in the plan network.[1] For example, a consumer could receive a surprise bill after he/she receives emergency services from an out-of-network provider or nonemergency services from an out-of-network provider working in an in-network facility.

As these situations imply, surprise billing is rooted in most private insurers' use of provider networks. Therefore, this report begins with a discussion of the relationship between provider network status and private health insurance billing before discussing various aspects of federal surprise billing requirements.[2]

Federal surprise billing requirements were implemented by the No Surprises Act, part of the Consolidated Appropriations Act, 2021 (P.L. 116-260). No federal requirements directly addressed surprise billing prior to the passage of the No Surprises Act, but over half of states had implemented policies to address surprise billing in some capacity.

This report answers frequently asked questions about the nature of the federal surprise billing requirements and corresponding consumer protections, the interaction between federal and state surprise billing requirements, and the enforcement of the federal provisions. A summary of various federal surprise billing requirements can be found in an appendix table (**Table C-1**). The Departments of Health and Human Services (HHS), the Treasury, and Labor were developing implementation regulations at the time this report was being drafted; therefore, the report reflects statutory language and certain aspects of the report may be further defined through the regulatory process. Although the requirements are discussed in the present tense to facilitate easy reading, they will come into effect on January 1, 2022.

The body of the report generally does not discuss implementing requirements (e.g., required rulemaking) and other deadlines and deliverables, but all deadlines and deliverables included in the No Surprises Act are summarized at the end of the report (**Table A-1**).

The No Surprises Act also included other provisions that relate to the topic of surprise billing but do not relate directly to the requirements on insurers and providers regarding the cost of, and payment for, services provided in surprise billing situations. Some of these "other provisions" that are not discussed or referenced within the body of this report are summarized in **Appendix B**.

Private Health Insurance Billing Overview

The charges and payments for health care items or services under private health insurance are often the result of contractual relationships among consumers, insurers, and providers for a given health plan.

[1] A consumer may be surprised to receive larger-than-expected medical bills for other reasons; for example, the surprise component may arise because a consumer misunderstands the terms of his or her health insurance policy and receives a bill for an unexpected amount. Such other reasons generally are outside the scope of this report and are not included in this report's usage of the term *surprise billing*.

[2] A previous Congressional Research Service (CRS) report on surprise billing discussed a selected set of policy issues and legislative approaches relating to the topic. See CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

Health care providers establish dollar amounts for the services they furnish; such amounts are referred to as *charges* and reflect what providers think they should be paid. However, the actual amounts a provider is paid for furnishing services vary and may not be equal to the provider-established charges. The amounts a provider receives for furnished services, and how the payment is divided between the insurer and the consumer, can vary due to a number of factors, including (but not limited to) the provider's network status (i.e., in network or out of network), whether the services are covered under the plan, whether an insurer pays for services provided by out-of-network providers, enrollee cost-sharing requirements, whether a provider can bill the consumer for an additional amount above the amount paid by the consumer in the form of cost sharing, and the insurer's contract with the provider.

Figure 1 highlights the effects of these distinctions. The following sections discuss them in the context of in-network and out-of-network coverage.

In-Network Coverage

With private insurance, the amount paid for a covered item or service is often contingent on whether a consumer's insurer has contracted with the provider. Insurers typically negotiate and establish separate contracts with hospitals, physicians, physician organizations (such as group practices and physician management firms), and other types of providers.[3] If a particular insurer has a contract with a specific provider, that provider generally is considered to be part of that insurer's provider network (i.e., that provider is considered *in network*).

The contents of contracts between insurers and providers vary and typically result from negotiations between the two parties; however, these contracts generally specify the amounts providers are to receive for providing in-network services to consumers (i.e., *negotiated amounts*).[4] Negotiated amounts typically are lower than what providers would otherwise charge had they not contracted with an insurer.

When an in-network provider furnishes a service to a consumer, the insurer and the consumer typically share the responsibility of paying the provider the negotiated amount established in the contract.[5] The consumer's portion of the negotiated amount is determined in accordance with the cost-sharing requirements of the consumer's health plan (e.g., deductibles, co-payments, coinsurance, and out-of-pocket limits; see **Figure 1**).[6] If the consumer receives covered services from in-network providers, the consumer generally has lower cost-sharing requirements than if he/she had received the same services out of network. Generally, in-network providers are contractually prohibited from billing consumers for any additional amounts above the negotiated amount (i.e., *balance bill*).

[3] In some instances, an insurer may negotiate jointly with multiple entities. For example, an insurer may negotiate one contract with a large health system that combines physicians and hospitals.

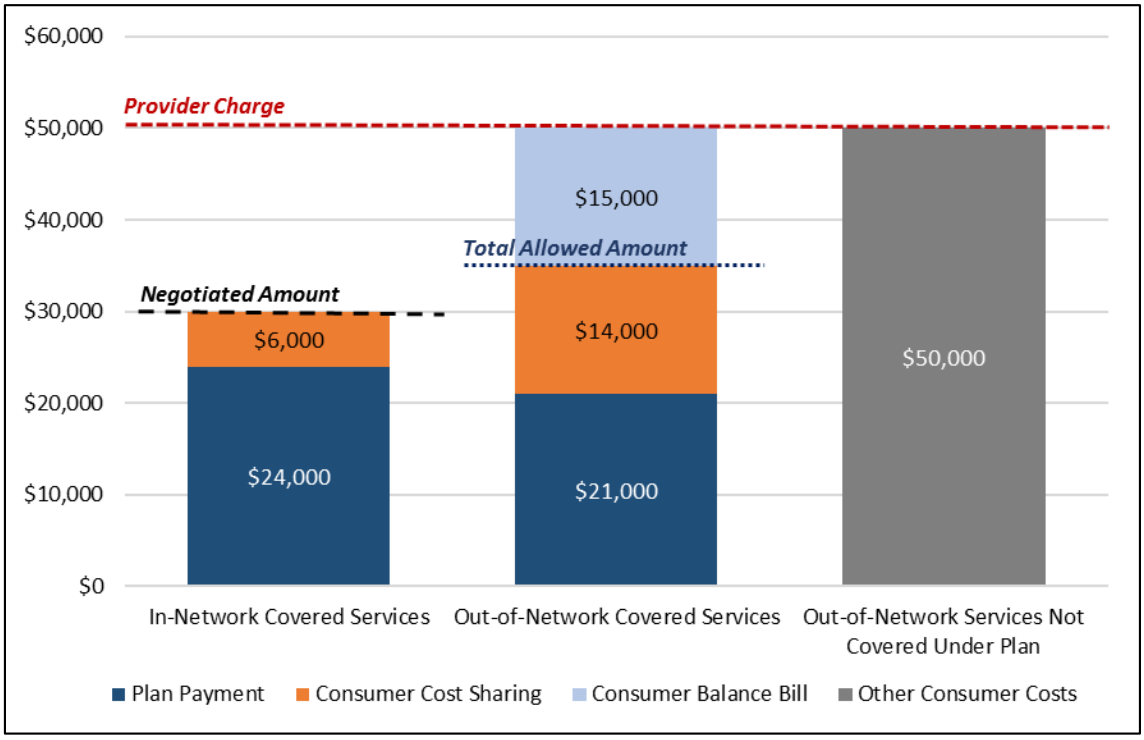
[4] The negotiated amount an insurer pays for particular services typically varies among all providers that have contracted with the insurer. Such discrepancies are due, in part, to the market power of a given insurer relative to the market power of a given provider.

[5] Some services may be provided without cost to the consumer. For example, plans generally are required to provide coverage for certain preventive health services without imposing cost sharing. 42 U.S.C. §300gg-13.

[6] For definitions of such cost-sharing terms, see Centers for Medicare & Medicaid Services (CMS), *Glossary*, at https://www.healthcare.gov/glossary/.

Figure 1. Illustrative Examples of Billing Under Private Health Insurance

(20% coinsurance for in-network services and 40% coinsurance for out-of-network services)



Source: Congressional Research Service.

Notes: These examples are for illustrative purposes only; they do not represent the full spectrum of possible billing scenarios. The examples assume the consumer's deductible has been met, the in-network out-of-pocket (OOP) limit has not been reached, and there is no out-of-network OOP limit. In the example, Provider Charge = $50,000, Total Allowed Amount = $35,000, and Negotiated Amount = $30,000. Consumer cost-sharing amounts are based on these totals, where applicable. Outside of this example, coinsurance rates for in-network and out-of-network services may vary by plan.

Out-Of-Network Coverage

When no contract between an insurer and a provider exists, the provider is considered to be out of the insurer's provider network. The total costs for services furnished by an out-of-network provider, and who pays for such services, depend on a number of factors; one key factor is whether the plan covers out-of-network services in the first place. Generally, point-of-service plans and preferred provider organization (PPO) plans cover out-of-network services. By contract, exclusive provider organization plans and health maintenance organization (HMO) plans generally cover only services by providers within the plans' networks (except in an emergency or, beginning in 2022, in certain surprise billing situations).

Insurer Pays for Out-Of-Network Services

When an insurer covers out-of-network services, both the consumer and the insurer contribute some amount to the provider, with the consumer's amount determined in accordance with the plan's cost-sharing requirements. Consumer cost-sharing requirements for services provided by an out-of-network provider may be separate from (and typically are greater than) cost-sharing requirements for the same services provided by an in-network provider. For example, a plan may have different deductibles for in-network and out-of-network services.

Table 1 provides an example of how cost-sharing requirements may differ for in-network and out-of-network services.

Table 1. Illustrative Example of Cost-Sharing Requirements for a Plan That Covers Out-of-Network Services

Selected Cost-Sharing Requirements	In Network	Out of Network
Deductible	$350 overall deductible	
Coinsurance Rate (Outpatient Surgery)	15% of negotiated amount	35% of total allowed amount
Out-of-Pocket Limit	$7,000 (includes amounts for in-network providers only)	No limit

Source: Congressional Research Service.

Notes: This example is for illustrative purposes only; it does not represent the full spectrum of possible cost-sharing requirements.

Cost-sharing requirements indicate how an insurer and a consumer will share the cost for a service, but the insurer determines the total amount that cost-sharing requirements will be based on—often referred to as the *total allowed amount*.[7] (Because there are no contracts between out-of-network providers and insurers, there are no negotiated amounts on which to base consumer cost sharing.)

The total allowed amount does not necessarily match the negotiated amount insurers may have contracted with other providers or the provider charge amount for that service.[8] In other words, there could be a discrepancy between the insurer and the provider over the total cost of care.

Insurers have their own methodologies for calculating the total allowed amount. They may do so by incorporating the *usual, customary, and reasonable rate* (UCR), which is the amount paid for services in a geographic area based on what providers in the area usually charge for the same or similar medical services.[9]

If an out-of-network provider's total charge for a service exceeds the total allowed amount determined by the insurer (and if allowed under law), the provider may directly bill (i.e., balance bill) a consumer for the amount of that difference (sometimes referred to as the *excess charge*; see

[7] Under current law, plans that cover in-network emergency services are required to recognize the greatest of the following three payment standards as the total amount for out-of-network emergency services: (1) the median amount the insurer has negotiated with in-network providers for the furnished service; (2) the usual, customary, and reasonable amount the insurer pays out-of-network providers for the furnished service; or (3) the amount that would be paid under Medicare for the furnished service. Beginning in 2022, this *greatest-of-three* payment standard will no longer apply and will be replaced by the payment standard implemented by the No Surprises Act, as applicable to emergency services. For more information on the greatest-of-three payment standard, see "Existing Requirements Addressing Surprise Billing" in CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

[8] If a total allowed amount is larger than a negotiated rate, then the consumer's payment for out-of-network services could be larger than a corresponding payment for in-network services, regardless of whether the cost-sharing terms are identical for in-network and out-of-network care. For example, a 20% coinsurance rate on a $150 total allowed amount would result in a larger payment ($30) than a 20% coinsurance rate on a $100 negotiated rate ($20).

[9] CMS, "UCR (Usual, Customary, and Reasonable)," in *Glossary*, at https://www.healthcare.gov/glossary/ucr-usual-customary-and-reasonable/.

Figure 1). The consumer would therefore be responsible for paying amounts associated with any cost-sharing requirements *and* the balance bill amount.

The provider is responsible for collecting any balance bill amounts; from an administrative standpoint, it is considered more difficult to collect these balance bill amounts than to collect payments from insurers.[10] In some instances, providers may settle with balance-billed consumers for amounts that are less than the total balance bill.

Insurer Does Not Pay for Out-of-Network Services

If a consumer receives out-of-network care not covered by his or her plan, the consumer is responsible for paying the total amount charged by the provider for the out-of-network services (represented in **Figure 1** as "Out-of-Network Services Not Covered Under Plan").[11] Although the consumer pays the provider in this instance, the consumer costs are not technically cost sharing (because the insurer is not sharing costs with the consumer), nor are they the balance remaining after the provider receives certain payments. Therefore, this report refers to these costs as *other consumer costs*.[12]

Similar to balance bills, providers are responsible for collecting these other consumer costs. Providers ultimately may decide to settle with the consumer for amounts that are less than the initial charges.

Federal Requirements Addressing Surprise Billing

Federal surprise billing requirements were established as part of the No Surprises Act, Title I of Division BB of the Consolidated Appropriations Act, 2021. The requirements will take effect starting with plan years that begin on or after January 1, 2022.[13] The No Surprises Act placed requirements on insurers and providers to create a degree of consumer protection in specified surprise billing situations.[14]

The following section answers frequently asked questions about the broadly applicable consumer protections that will be required in specified surprise billing situations and the corresponding requirements that will apply to both insurers and providers.

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[10] Loren Adler et al., *State Approaches to Mitigating Surprise Out-of-Network Billing*, USC-Brookings Schaeffer Initiative for Health Policy, February 2019, p. 6, at https://www.brookings.edu/wp-content/uploads/2019/02/Adler_et-al_State-Approaches-to-Mitigating-Surprise-Billing-2019.pdf.

[11] Under current law, plans that cover in-network emergency services are required to cover out-of-network emergency services, even if the plans would not cover other out-of-network care. Beginning in 2022, these plans also will be required to cover services provided in specified surprise billing situations. See **Table 2**. For more information on the current law requirement, see "Existing Requirements Addressing Surprise Billing" in CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

[12] A consumer generally is responsible for the entire bill if he or she receives a service that is not covered by the plan (i.e., an excluded service), regardless of whether the consumer received the service from an in-network provider.

[13] Prior to enactment of federal surprise billing requirements, a more limited set of related requirements applied to consumer cost sharing for, and plan coverage of, out-of-network emergency services and consumer cost-sharing requirements for ancillary provider services furnished at in-network facilities.

[14] Federal surprise billing requirements were incorporated into the Public Health Service Act (PHSA), Employee Retirement Income Security Act of 1974 (ERISA), and Internal Revenue Code (IRC). Although the provisions in these statutes are substantively similar, the differences reflect, in part, the applicability of each statute to private plans. The PHSA's provisions apply broadly across private plans, whereas ERISA and the IRC focus primarily on group plans. This report references only the *U.S. Code* citations associated with the PHSA requirements.

In many specified situations, the surprise billing consumer protections and corresponding insurer/provider requirements are structured similarly. However, some distinctions exist with respect to how federal requirements apply to specific surprise billing situations. Such distinctions are noted throughout the report. Furthermore, a table that summarizes various federal surprise billing requirements, by situation, can be found in **Table C-1**.

What Plan Types Are Addressed?

Federal private health insurance requirements generally vary based on the segment of the private health insurance market in which the plan is sold (i.e., individual market, fully-insured small group market, fully-insured large group market, or self-insured market).[15] Some requirements apply to all market segments, whereas others apply only to selected market segments.[16] For example, plans offered in the individual and fully insured small-group markets must comply with the federal requirement to cover the essential health benefits; however, plans offered in the fully insured large-group market and self-insured plans do not have to comply with this requirement.

Federal surprise billing requirements generally apply to individual market plans, fully insured small-group and large-group plans, and self-insured plans.[17] In addition, many surprise billing requirements apply to Federal Employees Health Benefits (FEHB) Program plans and grandfathered plans.[18] However, of the surprise billing requirements described in this report (see "When Do Surprise Billing Requirements Apply?"), the continuity-of-care and provider-directory surprise billing requirements do not apply to FEHB Program plans or grandfathered plans. Emergency service-related surprise billing requirements apply only to plans in the aforementioned markets that cover emergency services in general.

When Do Surprise Billing Requirements Apply?

Federal surprise billing requirements apply to a variety of services and provider types. Specifically, surprise billing requirements address the following:

- Out-of-network emergency services
- Out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services

[15] For an overview of federal requirements on private health insurance plans, see CRS Report R45146, *Federal Requirements on Private Health Insurance Plans*.

[16] Consumers may have other types of private coverage (e.g., short-term, limited-duration insurance) that may not be subject to the same requirements applicable to individual, small-group, large-group, or self-insured plans. For more information on how private health insurance requirements apply to these types of coverage, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*.

[17] In some instances, individual, small-group, and large-group plans may be subject to state surprise billing requirements. See "How Do Federal Surprise Billing Requirements Interact with State Surprise Billing Laws?"

[18] The Federal Employees Health Benefits (FEHB) Program provides health insurance to federal employees, retirees, and their dependents. For more information on FEHB, see CRS Report R43922, *Federal Employees Health Benefits (FEHB) Program: An Overview*. The Patient Protection and Affordable Care Act (ACA; P.L. 111-148, as amended) provided that group health plans and health insurance coverage in which at least one individual was enrolled as of the ACA's enactment (March 23, 2010) could be grandfathered. For as long as a plan maintains its grandfathered status, it is exempt from specified federal health insurance requirements established under the ACA. For more information on grandfathered plans, see CRS Report R46003, *Applicability of Federal Requirements to Selected Health Coverage Arrangements*. See 5 U.S.C. §8902(p) and 42 U.S.C. §18011(a)(5), respectively.

- Out-of-network nonemergency, non-ancillary services provided at an in-network facility
- Out-of-network nonemergency, ancillary services provided at an in-network facility[19]
- Out-of-network air ambulance services
- Services scheduled at least three business days in advance
- Out-of-network services from a provider that initially was in-network but subsequently became out-of-network during the course of treatment (i.e., continuity of care)
- Out-of-network services from a provider that the consumer assumed was in-network based on incorrect information from the plan (e.g., incorrect provider directory information)

What Consumer Protections Apply in Surprise Billing Situations?

Surprise billing consumer protections generally take one of two forms: financial protections and informational protections. *Financial protections* generally limit the financial liability of consumers who inadvertently receive out-of-network care, which typically costs more than in-network care. *Informational protections* generally provide consumers with information on their provider's network status before the consumers receive care. If a consumer is notified before receiving care that he or she will be seen by an out-of-network provider, the consumer could decide whether to see the out-of-network provider or could seek a different, in-network provider. A consumer who is able to make this sort of informed decision about where to receive care may be less likely to be surprised by a bill that is higher than anticipated due to the provider's network status.

The types of consumer protections vary depending on the surprise billing situation. Some surprise billing situations have requirements that relate to both financial and informational protections; other surprise billing situations have requirements that relate to only one type of protection. For example, some surprise billing situations apply financial protections only if informational protections are not applied appropriately, whereas other surprise billing situations apply financial protections in all instances.

Financial Protections

Surprise billing financial protections apply to all surprise billing situations except when services are scheduled at least three business days in advance.[20] These protections reduce the amount

[19] *Ancillary services* include services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology; certain diagnostic services (including radiology and laboratory services); items and services provided by other specialty practitioners; and items and services provided by an out-of-network provider if there is no in-network provider that can provide the service. 42 U.S.C. §300gg-132(b)(2).

[20] The financial protections that apply to situations in which services are scheduled three days in advance vary depending on the consumer's insurance status. The financial protections do not apply to consumers with private health insurance who are submitting a claim through their plan; however, these protections do apply to *uninsured individuals* (defined as individuals who are not enrolled in a private health insurance plan, federal health care program, or FEHB Program plan, and individuals who are enrolled in a private health insurance plan but are not seeking to have the scheduled service covered by their plan). Specifically, in this situation, uninsured individuals would have access to a patient-provider dispute resolution process if they were charged an amount that is "substantially in excess" of an initially provided good-faith estimate of costs. Under the patient-provider dispute resolution process, an unaffiliated

consumers pay in cost sharing and balance bills (when consumers have plans that cover out-of-network care) and the amount consumers pay in other consumer costs (when consumers have plans that do not cover out-of-network care).[21] Specific consumer protections vary slightly across surprise billing situations, as specified in **Table 2**.

Table 2. Specified Consumer Financial Protections in Surprise Billing Situations
(where applicable)

Surprise Billing Situation(s)	Consumer Financial Protections
Out-of-network emergency services; out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; out-of-network nonemergency, non-ancillary services provided at an in-network facility; and out-of-network nonemergency, ancillary services provided at an in-network facility	• Cost-sharing requirements cannot be greater than what they would have been had the service been provided in-network • Cost-sharing amounts are to be calculated based on the median in-network rate for the service or plan (e.g., a 20% coinsurance rate would be based on the median in-network rate)[a] • Cost-sharing amounts count toward the in-network deductible and out-of-pocket maximum • Consumer cannot be balance billed directly by the provider
Out-of-network air ambulance services	• Cost-sharing requirements are the same as what they would have been had the service been provided in-network • Coinsurance and deductible amounts are to be calculated based on in-network rates • Cost-sharing amounts count toward the in-network deductible and out-of-pocket maximum • Consumer cannot be balance billed directly by the provider
Out-of-network services from a provider that initially was in network but subsequently became out of network during the course of treatment (i.e., continuity of care)	• Benefits are provided under the same terms that would have applied before the change in provider network status • Consumer effectively cannot be balance billed directly by the provider
Out-of-network services from a provider that the consumer assumed was in-network based on incorrect information from the plan (e.g., incorrect provider directory information)	• Cost-sharing requirements cannot be greater than what they would have been had the service been provided in-network • Cost-sharing amounts count toward the in-network deductible and out-of-pocket maximum • Consumer effectively cannot be balance billed directly by the provider • Excess amounts paid by individuals for services are to be refunded, with interest

entity would determine the charged amount that the individual would be responsible for paying. 42 U.S.C. §300gg-137.

[21] In general, surprise billing financial protections require plans to cover certain out-of-network services. Because plans generally must contribute some amount to these services, even if the plans otherwise would not contribute anything to out-of-network care, consumers typically will not be responsible for *other consumer costs* (as such term was used in the "Private Health Insurance Billing Overview") in applicable surprise billing situations.

Source: Congressional Research Service summary of various insurer requirements at 42 U.S.C. §§300gg-111(a), 300gg-111(b), 300gg-112(a), 300gg-113(a)(2), and 300gg-115(b), and provider requirements at 42 U.S.C. §§300gg-131, 300gg-132, 300gg-135, 300gg-138, and 300gg-139.

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

a. If the service is provided in a state that has an applicable surprise billing law or an all-payer model agreement, the cost-sharing amount is to be calculated in accordance with such law or agreement.

In general, and regardless of whether the consumer's plan covers out-of-network care, the consumer will pay only in-network cost-sharing amounts or rates when he/she receives out-of-network care in surprise billing situations. For example, if a plan has a $100 co-payment for in-network emergency services, the plan also must have a $100 co-payment for out-of-network emergency services. Furthermore, out-of-network providers generally are prohibited from balance billing the individual for amounts in addition to the consumer cost sharing.

Roughly half of the surprise billing situations further specify that, in general, the cost-sharing amounts are to be calculated as if total cost for the service were the median of all amounts the insurer had negotiated with various providers for that service in 2019, as adjusted for inflation,[22] referred to as the *median in-network amount*. (These scenarios are specified in **Table 2**.) As shown in **Figure 2**, in specified surprise billing situations, a 20% coinsurance rate would be based on the insurer's median in-network amount for 2019, as adjusted for inflation, instead of on an amount negotiated with a particular provider or on the insurer's total allowed amount.

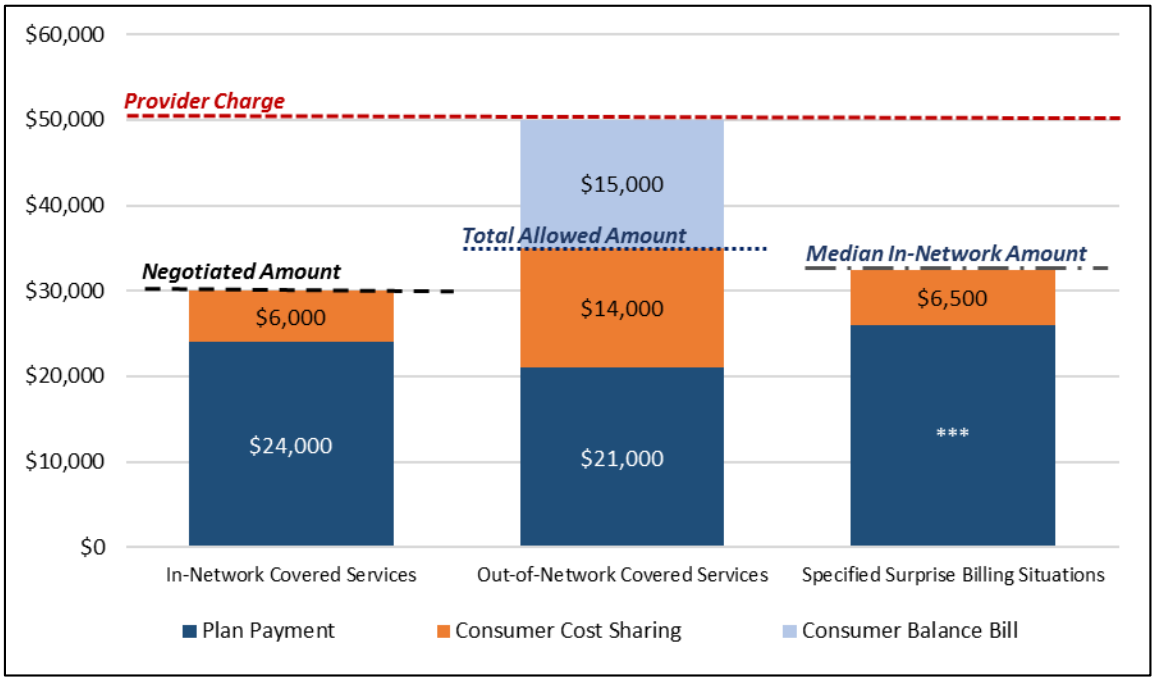
However, if the service were provided in a state with an applicable surprise billing law or an all-payer model agreement, the cost-sharing amount would be calculated in accordance with such law or agreement.[23]

[22] More specifically, the amount is based on the 2019 rates negotiated with providers in the same or a similar specialty, provided in the same geographic region, and by the same plan type (e.g., small group, large group), as annually adjusted by the Consumer Price Index for All Urban Consumers. If an insurer offers a plan in a geographic region where it did not offer a plan in 2019 or the plan does not have sufficient information to determine a median in-network amount for 2019, consumer cost-sharing amounts are determined based on a different methodology. See the definition of *Qualifying Payment Amount*, 42 U.S.C. §300gg-111(a)(3)(E).

[23] For example, see Maryland's all-payer hospital rate regulation system at Centers for Medicare & Medicaid Services, *Maryland All-Payer Model*, https://innovation.cms.gov/innovation-models/maryland-all-payer-model.

Figure 2. Illustrative Examples of Consumer Billing, Including Specified Surprise Billing Situations

(20% coinsurance for in-network services and specified surprise billing situations; 40% coinsurance for out-of-network services)



Source: Congressional Research Service.

Notes: These examples are for illustrative purposes only; they do not represent the full spectrum of possible billing scenarios. The examples assume the consumer's deductible has been met, the in-network out-of-pocket (OOP) limit has not been reached, and there is no out-of-network OOP limit. In the example, Provider Charge = $50,000; Total Allowed Amount = $35,000; Median In-Network Amount = $32,500; and Negotiated Amount = $30,000. Consumer cost-sharing amounts are based on these totals. Outside of this example, coinsurance rates for in-network and out-of-network services may vary by plan type.

*** = Amount paid by plan, which is determined through a separate process. **Median In-Network Amount** = the median of the plan's negotiated amounts for that service in 2019, as adjusted for inflation. Median in-network amount may be higher or lower than a particular in-network provider's negotiated amount. **Specified Surprise Billing Situations** = out-of-network emergency services; out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; out-of-network nonemergency, non-ancillary services provided at an in-network facility; and out-of-network nonemergency, ancillary services provided at an in-network facility.

Except in the context of emergency services, consumer financial protections generally apply only to covered services (i.e., services that would be covered by the plan if they were provided in network). For example, if a particular service would not be covered by the plan if provided by an in-network provider, the service would not be subject to the surprise billing protections if provided by an out-of-network provider at an in-network facility.

In some situations, surprise billing consumer financial protections always apply; in other instances, the consumer protections apply only if specified criteria are met. Most commonly, the protections apply only if the consumer does not receive notice and give consent to receiving such out-of-network care. **Table 3** lists surprise billing situations where consumer protections are conditional upon criteria.

Table 3. Criteria That Cause Surprise Billing Consumer Financial Protections to Apply

(for situations in which protections are conditional upon certain criteria)

Surprise Billing Situation	Criteria for Financial Protections to Apply
Out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services	Notification and consent requirements are not met; OR Consumer is not in a condition to receive the notification and provide informed consent; OR Consumer is not able to travel using nonmedical or nonemergency transportation; OR Other conditions specified by the Secretaries of Health and Human Services, Labor, and the Treasury.
Out-of-network nonemergency, non-ancillary services provided during a visit at an in-network facility	Notification and consent requirements are not met.
Out-of-network services from a provider who initially was in network but subsequently became out of network during the course of treatment	Consumer elects to continue receiving care from the now out-of-network provider. Protections would last for, at most, 90 days.
Out-of-network services from a provider that the consumer assumed was in-network based on incorrect information from the plan	Consumer must have received incorrect information from the plan's provider database or provider directory that the provider was in network OR In the event the individual was not provided with such information, the consumer must have reached out to the plan for information on the provider's network status and been incorrectly told the provider was in network.

Source: Congressional Research Service summary of various requirements at 42 U.S.C. §§300gg-111(a)(3)(C), 300gg-111(b)(1), 300gg-113(a)(2), and 300gg-115(b).

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

Informational Protections

Because surprise billing may occur when a consumer is *unknowingly* treated by a provider outside of the consumer's health insurance plan's network, some surprise billing protections include requirements that seek to provide consumers with more information about the providers in their network and/or the care they are scheduled to receive. Theoretically, this additional information provides consumers with the ability to make an informed decision about their medical care *before* they receive such care. These requirements alone do not eliminate surprise billing charges, but they reduce the prevalence of *unexpected* out-of-network use.[24]

The surprise billing informational protections are structured as consumer notices and provider directories.[25] Most often, the appropriate application of informational protections precludes the consumer from receiving financial protections in surprise billing situations (see **Table 3**).

[24] More explicitly, although such requirements may reduce the prevalence of surprise billing, consumers who expectedly receive out-of-network care still may be balance billed or responsible for other consumer costs.

[25] Insurers and providers are subject to more general informational requirements that are not associated with any specific surprise billing situations. For example, insurers are required to make publicly available, post on their websites, and include on each explanation of benefits information on balance billing prohibitions. For information on the more general surprise billing-related informational requirements included in the No Surprises Act (part of the Consolidated Appropriations Act, 2021; P.L. 116-260), see **Appendix B**.

Notification requirements affect the following surprise billing situations:

- Out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services
- Out-of-network nonemergency, non-ancillary services provided at an in-network facility
- Services scheduled at least three business days in advance
- Out-of-network services from a provider that initially was in network but subsequently became out of network during the course of treatment (i.e., continuity of care).

Provider directory requirements affect the following surprise billing situation:

- Out-of-network services from a provider that the consumer assumed was in network based on incorrect information from the plan (e.g., incorrect provider directory information).

Notification

In the surprise billing context, consumer notifications are intended to inform the consumer of the network status of the provider that he or she is scheduled to receive services from, as well as of other specified pieces of information (see **Table 4**). Depending on the surprise billing situation, this information may be provided by the insurer and/or by the provider. In theory, a consumer scheduled to receive services from an out-of-network provider could use this information to either keep the scheduled services with the out-of-network provider or attempt to find an in-network provider.

Depending on the surprise billing situation, consumer notification may affect the surprise billing financial protections applicable to that situation (see **Table 3**). Most commonly, notifications (and consumer consent) are used to satisfy criteria that exempt providers from having to apply consumer financial protections in specified surprise billing situations. For example, certain out-of-network providers in an in-network facility can provide notice to consumers in advance of providing care. If the consumer is provided with such notice and consents to receiving such care, the financial protections associated with that surprise billing situation would not apply;[26] by consenting to and receiving the out-of-network care, the consumer is acknowledging that he or she is willing to pay more to see the out-of-network provider.

By contrast, in the continuity of care surprise billing situation (i.e., situations where a provider is initially in network but subsequently becomes out of network during the course of a consumer's treatment), the notification is used to inform the consumer of the provider's network status and of the consumer's right to receive specified financial protections.[27]

[26] 42 U.S.C. §300gg-132(d), as referenced by 42 U.S.C. §300gg-111(b).

[27] 42 U.S.C. §300gg-113(a)(2).

Table 4. Information Included in Surprise Billing Notices

Surprise Billing Situation(s)	Provided By	When Provided	Required Information	Interaction with Financial Protections
Out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; and out-of-network nonemergency, non-ancillary services provided at an in-network facility;	Provider	For services scheduled at least 72 hours in advance, not later than 72 hours before the service is provided. For services scheduled within 72 hours of receiving the service, on the date the appointment is made.	• Statement that the provider is an out-of-network provider • Good-faith estimate of the service charges • List of in-network providers at the facility (if applicable) • Information on whether prior authorization or other care management limitations are required • Statement that consent to receive services from out-of-network provider is optional	Notification and consent requirements must be met in order for (or as part of criteria for) financial protections to not apply.
Services scheduled at least three business days in advance	Insurer with information received from provider[a]	For services scheduled at least 10 business days in advance (or if requested by the individual), not later than 6 business days after the date of scheduling. For services scheduled at least three business days in advance, not later than two days after the date of scheduling. (The Secretary may modify the timing requirements for services that have low utilization or significant variation in costs.)	• Information on the provider's network status • If the provider is in network, the negotiated rate for the service • If the provider is out of network, a description of how information on in-network providers can be obtained • Good-faith estimate of provider charges (provided to the insurer by the provider) • Good-faith estimate of the amount of charges the plan will cover • Good-faith estimate of the amount of cost-sharing the	No financial protections are associated with this surprise billing situation.[b]

Surprise Billing Situation(s)	Provided By	When Provided	Required Information	Interaction with Financial Protections
			consumer will be responsible for • Good-faith estimate of the amount the consumer has incurred toward deductibles and out-of-pocket maximums • Disclaimer that the coverage for the service is subject to medical management techniques (where applicable) • Disclaimer that the information provided in the notice is only an estimate • Any other information or declaimers that the insurer deems appropriate	
Out-of-network services from a provider that initially was in network but subsequently became out of network during the course of treatment (i.e., continuity of care)	Insurer	When there is a network contract termination between a plan and provider of a continuing care patient.	• Statement that the contract between the insurer and provider has been terminated • Statement informing the consumer of his or her right to elect continued transitional care from the provider	Notification informs the consumer of the option to elect to receive financial protections.

Source: Congressional Research Service summary of various requirements at 42 U.S.C. §§300gg-111(a)(3)(C), 300gg-111(f), 300gg-111(b)(1), 300gg-113(a)(2), 300gg-132(d), and 300gg-136.

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

a. If the consumer is enrolled in a private health insurance plan and is seeking to have the plan cover the service, providers are required to submit a good-faith estimate of the expected charges to the insurer; that estimate is subsequently incorporated into the insurer notice to the consumer. In all other instances, providers are required to give this information directly to the consumer. 42 U.S.C. §300gg-136.

b. With respect to situations in which services are scheduled at least three business days in advance, although there are no financial protections associated with consumers enrolled in private health insurance who are submitting a claim through their plan, there are financial protections available for uninsured individuals (defined as individuals who are not enrolled in a private health insurance plan, federal health care program, or Federal Employees Health Benefits Program plan and individuals who are enrolled in a private health insurance plan but are not seeking to have the scheduled service covered by their plan). For uninsured individuals in this situation, the provider will provide a notice directly to the individual (see table note a) that includes a good-faith estimate of provider charges. If the uninsured

individual were subsequently charged an amount "substantially in excess" of the initially provided good-faith estimate of costs, the uninsured individual would have access to a patient-provider dispute resolution process. Under this process, an unaffiliated entity would determine the charged amount that the individual would be responsible for paying. 42 U.S.C. §300gg-137.

Provider Directories

Provider directories are repositories of information for consumers about the providers that are in a plan's network. Both insurers and providers are subject to provider directory requirements that seek to ensure consumers have, or have access to, accurate information about which providers are within their plans' networks. Insurer provider directory requirements address print provider directories, web-based provider directories (i.e., databases), and methods by which individuals can verify a provider's network status by calling or electronically communicating with the insurer.[28] Providers are required to support insurer compliance with such requirements by providing insurers with the necessary information for the directory.[29]

If a consumer uses a provider directory or communicates electronically or by phone with the insurer and receives incorrect information about the provider's network status, the consumer is provided financial protections that limit costs of services from providers that the consumer thought were in network.[30]

How Much Do Insurers Pay Providers in Surprise Billing Situations?

As discussed in the "Private Health Insurance Billing Overview" section, in general, payment for out-of-network services depends on whether the plan covers out-of-network benefits. Regardless of whether a plan provides out-of-network benefits, there is no contract establishing a set payment rate between an insurer and an out-of-network provider—that is, there is no amount that providers and insurers both recognize as the total cost for care.

Where federal surprise billing financial protections apply, insurers (whether or not they provide out-of-network benefits) generally are required to pay out-of-network providers some amount for furnishing services. Federal requirements specify the methodologies insurers must use to determine the payment amount for these services. When coupled with requirements that limit the amount consumers pay providers in surprise billing situations, these methodologies effectively result in the provider and the insurer recognizing the same total price for care.

Under federal requirements, most surprise billing situations require the insurer to make an initial payment (or notice of denial of payment) to the provider, after which the provider or the insurer may initiate open negotiations to determine how much the health insurer must pay the out-of-network provider.[31] If negotiations are unsuccessful, the parties may use an independent dispute resolution (IDR) process.

However, the federal methodology does not apply in all situations. If the services were provided in a state that has its own surprise billing law that applies to a given plan type, provider type, and service, for example, the federal methodology would not be used; instead, the state law methodology would be used to determine how much the health insurer must pay the out-of-

[28] The methods by which individuals can verify a provider's network status by calling or electronically communicating with the insurer are referred to in statute as a *response protocol*. 42 U.S.C. §300gg-115.

[29] 42 U.S.C. §300gg-139.

[30] 42 U.S.C. §300gg-115(b).

[31] In some situations, surprise billing requirements are conditional upon certain criteria being met (see **Table 3**). In the event that surprise billing financial protections do not apply, for example because certain out-of-network providers at in-network facilities satisfied notice and consent requirements, this methodology would not be used.

network provider.[32] Relatedly, if these services were provided in a state that has an all-payer model agreement, the amount designated under the agreement would apply.

As shown in **Table 5**, federal requirements do not explicitly specify the methodologies for reimbursement in all surprise billing situations.

Table 5. Federal Payment Methodologies in Surprise Billing Situations with Consumer Financial Protections

Surprise Billing Situation(s)	Payment Methodology	Methodology Interaction with State Laws and Agreements
Out-of-network emergency services Out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services Out-of-network nonemergency, non-ancillary services provided at an in-network facility Out-of-network nonemergency, ancillary services provided at an in-network facility Out-of-network air ambulance services	Initial payment (or notice of denial of payment) followed by out-of-network provider or insurer option to initiate negotiation. If negotiation fails, either party may initiate an independent dispute resolution process.	Federal methodology does not apply in states with an all-payer model agreement or a surprise billing law in effect with respect to the applicable plan type, provider type, and service.[a]
Out-of-network services from a provider that initially was in network but subsequently became out of network during the course of treatment (i.e., continuity of care).	None specified in statute.	Not applicable.
Out-of-network services from a provider that the consumer assumed was in-network based on incorrect information from the plan (e.g., incorrect provider directory information).	None specified in statute.	Not applicable.

Source: Congressional Research Service summary of various requirements at 42 U.S.C. §§300gg-111(a)(1)(C)(iv), 300gg-111(a)(3)(K), 300gg-111(b)(1)(D), 300gg-112(b), 300gg-113, and 300gg-115.

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

a. Although federal law would defer to state air ambulance surprise billing laws in specified instances, states generally have been limited in their ability to enact air ambulance surprise billing laws as a result of the Airline Deregulation Act of 1978 (P.L. 95-504), which preempts state regulation of payment rates for certain air transportation carriers (including air ambulances). For a discussion of state attempts to address

[32] As an example, a state may have an emergency service surprise billing law that applies to fully insured plans and out-of-network emergency departments. If a consumer with a fully insured plan received emergency services from an emergency department in the state, the state methodology would be used to determine the total payment for the care. If a consumer with a *self-insured plan* received emergency services from an emergency department within the state, the federal methodology would be used, since the state law does not apply to self-insured plans. For a more in-depth discussion of this topic, see "How Do Federal Surprise Billing Requirements Interact with State Surprise Billing Laws?"

air ambulance surprise billing, see Government Accountability Office (GAO), *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk*, GAO-19-292, March 20, 2019, p. 19, at https://www.gao.gov/assets/700/697684.pdf.

Initial Payment

Where applicable, insurers are required to make an initial payment (or notice of denial of payment) to a provider within 30 calendar days of receiving a bill for services.[33]

Open Negotiation

After the insurer makes an initial payment (or notice of denial of payment), the out-of-network provider or the insurer may initiate open negotiations for the purpose of determining a mutually agreed-upon payment amount. The negotiations may be initiated during the 30-day period that begins on the day the out-of-network provider receives an initial payment (or notice of denial of payment) from the insurer regarding the out-of-network claim.[34] The provider and insurer then have 30 days from the date the negotiations were initiated (i.e., the open negation period) to reach an agreement. If the negotiations are successful, the insurer is required to pay to the provider the agreed-upon amount (or, after accounting for the initial payment, any remaining balance) within 30 days.[35]

After the 30-day open negotiation period, insurers and providers may access the IDR process; insurers and out-of-network providers may continue to negotiate a payment rate after initiation of the IDR process. If an agreement is reached between the parties after an IDR process is initiated and before a determination is made through the IDR process, then the agreed-upon rate will be treated as the final payment rate and there will be a process for determining how the parties will split the payment of the IDR process fees.[36]

Independent Dispute Resolution Process

If out-of-network providers and insurers cannot reach an agreement during the open negotiation period, then either party may seek to initiate the IDR process within a four-day period following the end of the open negotiation period.[37] The IDR process is a "baseball-style" arbitration process under which the out-of-network provider and the insurer submit to a neutral third party their best and final offers for the amount each party considers adequate payment. The neutral third party must review the offers and make a binding determination based on certain factors as to which offer is the reasonable payment that the out-of-network provider must receive as payment in full. Generally, the process is the same across the various scenarios in which it applies, with a few differences for situations involving services provided by air ambulance providers.

[33] 42 U.S.C. §§300gg-111(a)(1)(C)(iv), 300gg-111(b)(1)(C), and 300gg-112(a)(3)(A).

[34] 42 U.S.C. §§300gg-111(c)(1)(A) and 300gg-112(b)(1)(A).

[35] 42 U.S.C. §§300gg-111(c)(6) and 300gg-112(b)(6).

[36] 42 U.S.C. §§300gg-111(c)(2)(B) and 300gg-112(b)(2)(B).

[37] Either party may initiate the independent dispute resolution (IDR) process by providing notice to the other party and to the Secretaries of Health and Human Services (HHS), Labor, and the Treasury. 42 U.S.C. §§300gg-111(c)(1)(B) and 300gg-112(b)(1)(B).

Establishment of Independent Dispute Resolution Processes

The Secretaries of Health and Human Services, Labor, and the Treasury are required to create an independent dispute resolution process (IDR) process for emergency services and services provided by out-of-network providers at in-network facilities and an IDR process for air ambulance services before December 27, 2021. Many features of these processes are specified in statute and summarized in this report; however, the Secretaries are to further specify aspects of these IDR processes through regulations. For example, the Secretaries are to specify the criteria under which multiple services can be "batched" and considered as part of a single IDR determination. In another example, the Secretaries are to establish the certification process for IDR entities (including by incorporating process features specified in statute).

Source: 42 U.S.C. §§300gg-111(c)(2)(A) and 300gg-112(b)(2)(A); 42 U.S.C. §§300gg-111(c)(4)(A) and 300gg-112(b)(4).

Notes: More specifically and per statute, the certification process must ensure that certified IDR entities meet the following standards: has (directly or through contracts or other arrangements) sufficient medical, legal, and other expertise and sufficient staffing to make payment determinations on a timely basis; is not a health insurer or a provider or facility or a subsidiary of such type of entity; carries out the responsibilities of an IDR entity in accordance with law; meets the appropriate indicators of fiscal integrity; maintains the confidentiality of individually identifiable health information obtained during the IDR process; does not act as an IDR entity if not eligible due to a conflict of interest; and meets other requirements as determined by the Departments of Health and Human Services, Labor, and the Treasury.

Once the IDR process has been initiated, the insurer and the out-of-network provider have three business days to jointly select a neutral third party (i.e., *certified IDR entity*) to make a payment determination. The selected certified IDR entity cannot be party to the determination; cannot have a material familiar, financial, or professional relationship with the insurer or the provider; and cannot have a conflict of interest with the insurer or the provider. If the parties do not make a selection by the deadline, the Secretaries of HHS, the Treasury, and Labor are to assign a certified IDR entity.

No later than 10 days after the certified IDR entity has been selected, the out-of-network provider and the health insurer each must submit an offer for a payment amount (and other information requested by the certified IDR entity). The two parties also may submit other information relating to their offers.

The certified IDR entity must determine which offer is most reasonable based on factors specific to the situation in which the service was furnished.[38] The certified IDR entity is prohibited from considering certain factors when making a decision; **Table 6** lists the factors the certified IDR entity is required to consider or prohibited from considering when making a payment determination. The factors differ in situations involving air ambulances; **Table 7** lists the factors the certified IDR entity is required to consider or prohibited from considering when making a payment determination involving an air ambulance provider. The certified IDR entity's decision must come within 30 days of the entity's selection.[39]

After the certified IDR entity makes a payment decision, the plan must make the final payment to the provider within 30 days of the decision. The party whose offer was not chosen is responsible for paying IDR entity fees, and both parties must pay a fee to the Secretaries of HHS, the Treasury, and Labor to be used to carry out the IDR process.[40]

[38] 42 U.S.C. §§300gg-111(c)(5)(C) and 300gg-112(b)(5)(C).

[39] 42 U.S.C. §§300gg-111(c)(5)(A) and 300gg-112(b)(5)(A).

[40] 42 U.S.C. §§300gg-111(c)(5)(F), 300gg-111(c)(8), 300gg-112(b)(5)(E), 300gg-112(b)(8).

The certified IDR entity's decision is binding on both parties, unless the claim for payment is fraudulent or facts presented to the certified IDR entity were misrepresented. A binding payment determination generally is not subject to judicial review except in limited situations.[41]

During the 90 days after an IDR decision has been made, the party that initiated the IDR process may not subsequently attempt to initiate the IDR process to seek a payment determination involving the same opposing party and service that were subject to the initial notification.[42]

Table 6. Factors Considered During Independent Dispute Resolution (IDR) Process

(as applied to non-air ambulance surprise billing situations with a specified payment methodology)

Required to Be Considered	Prohibited from Being Considered
• The 2019 median in-network rate, as adjusted for inflation, for services that are comparable to the service under consideration and furnished in the same geographic region as the service under consideration[a] • The level of training, experience, and quality and outcomes measurements of the provider that furnished the service • Market share of the out-of-network provider or insurer in the geographic region where the service was provided • Acuity of the individual receiving the service or the complexity of furnishing the service to the individual • Teaching status, case mix, and scope of services of the out-of-network facility that furnished the service • Demonstrations of good faith efforts (or lack of good-faith efforts) made by the out-of-network provider or the insurer to enter into network agreements and, if applicable, contracted rates between the provider and the insurer during the previous four plan years • Other information requested by the IDR entity • Any information about the submitted offer supplied by the out-of-network provider or the insurer	• Usual and customary charges • Amount that would have been billed by the out-of-network provider for the service had the surprise billing protections not applied • Amount that public payors (including Medicare, Medicaid, the State Children's Health Insurance Program [CHIP], TRICARE, or the Department of Veterans Affairs) would pay or reimburse the out-of-network provider for the service

Source: 42 U.S.C. §§300gg-111(c)(5)(C) and (D).

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

a. More specifically, the median in-network rate is based on the 2019 rates negotiated with providers in the same or a similar specialty, provided in the same geographic region, and determined in accordance with the same plan type (e.g., small group, large group), as annually adjusted by the Consumer Price Index for All Urban Consumers. If an insurer offers a plan in a geographic region where it did not offer a plan in 2019 or the plan does not have sufficient information to determine a median in-network amount for 2019, consumer cost-sharing amounts are determined based on a different methodology. See definition of *Qualifying Payment Amount*, 42 U.S.C. §300gg-111(a)(3)(E).

[41] Payment determinations will be subject to judicial review in the cases described in 9 U.S.C. §10(a)(1)-(4). 42 U.S.C. §§300gg-111(c)(5)(E)(i)(II) and 300gg-112(b)(5)(D).

[42] 42 U.S.C. §§300gg-111(c)(5)(E)(ii) and 300gg-112(b)(5)(D).

Table 7. Factors Considered During Air Ambulance Independent Dispute Resolution (IDR) Process

Required to Be Considered	Prohibited from Being Considered
• The 2019 median in-network rate, as adjusted for inflation, for services that are comparable to the service under consideration and furnished in the same geographic region as the service under consideration[a] • Quality and outcomes measurements of the provider that furnished the service • Acuity of the individual receiving the service or the complexity of furnishing the service to the individual • Training, experience, and quality of the provider that furnished the service • Ambulance vehicle type, including the clinical capability level of the vehicle • Population density of the pick-up location (e.g., urban, suburban, rural, or frontier) • Demonstrations of good-faith efforts (or lack of good faith efforts) made by the out-of-network provider or the insurer to enter into network agreements and, if applicable, contracted rates between the provider and the insurer during the previous four plan years • Other information requested by the IDR entity • Any information about the submitted offer supplied by the out-of-network provider or the insurer	• Usual and customary charges • Amount that would have been billed by the out-of-network provider for the service had the surprise billing protections not applied • Amount that public payors (including Medicare, Medicaid, CHIP, TRICARE, or the Department of Veterans Affairs) would pay or reimburse the out-of-network provider for the service

Source: 42 U.S.C. §300gg-112(b)(5)(C).

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

a. More specifically, the median in-network rate is based on the 2019 rates negotiated with providers in the same or a similar specialty, provided in the same geographic region, and determined in accordance with the same plan type (e.g., small group, large group), as annually adjusted by the Consumer Price Index for All Urban Consumers. If an insurer offers a plan in a geographic region where it did not offer a plan in 2019 or the plan does not have sufficient information to determine a median in-network amount for 2019, consumer cost-sharing amounts are determined based on a different methodology. See definition of *Qualifying Payment Amount*, 42 U.S.C. §300gg-111(a)(3)(E).

How Are Surprise Billing Requirements Enforced?

Enforcement Mechanisms Applicable to Insurers

With respect to insurers, federal law adopts the existing applicable enforcement frameworks of the Public Health Service Act (PHSA), Employee Retirement Income Security Act of 1974

(ERISA), and Internal Revenue Code (IRC).[43] These existing enforcement frameworks are described briefly below.[44]

In general, the PHSA enforcement framework applies to health insurance issuers in the group and individual markets and gives states the option to be the primary enforcers of the federal requirements.[45] If the HHS Secretary determines a state has failed to "substantially enforce" the federal requirements in that state, however, the Secretary must enforce the requirements.[46] The Secretary may impose a civil monetary penalty on issuers that fail to comply with the PHSA's requirements. The maximum penalty imposed under the PHSA is currently $162 per day for each individual with respect to which such a failure occurs.[47]

Private-sector, employment-based group health coverage (including self-insured plans and coverage provided by health insurance issuers) generally is subject to the enforcement frameworks under both ERISA and IRC.[48] Among other enforcement mechanisms, the relevant ERISA provisions, subject to specified exceptions, authorize plan participants, other specified individuals, and the Secretary of Labor to file civil actions to enjoin any act or practice that violates ERISA.[49] The IRC, by contrast, subjects employers or group health plans to an excise tax for noncompliance with the IRC's requirements, generally at a rate of $100 per day for each affected plan participant during the noncompliance period.[50]

Enforcement Mechanisms Applicable to Providers

With respect to providers, federal law adopts an enforcement framework that is similar to that which applies to insurers under the PHSA.[51] Specifically, the law gives states the option to be the primary enforcers of the requirements on providers (including air ambulance services).[52] If the HHS Secretary determines that a state has failed to "substantially enforce" the federal requirements in that state, however, the HHS Secretary must enforce the requirements.[53]

Under the federal enforcement framework, the HHS Secretary may impose a civil monetary penalty on providers that fail to comply with federal surprise billing provisions. The maximum penalty the Secretary may impose is $10,000 per violation through procedures set forth in Section 1128A of the Social Security Act.[54] The HHS Secretary, however, must waive penalties for a provider that (1) does not knowingly violate and should not have reasonably known it violated the

[43] 42 U.S.C. §300gg-22(a)(1).

[44] For more information about these enforcement frameworks, see CRS Report R46637, *Federal Private Health Insurance Market Reforms: Legal Framework and Enforcement*.

[45] 42 U.S.C. §300gg-22(a)(1).

[46] 42 U.S.C. §300gg-22(a)(2).

[47] 42 U.S.C. §300gg-22(b)(2)(C)(i). The civil monetary penalty for violations of Title XXVII of the PHSA is adjusted annually for inflation. See 45 C.F.R. §102.3.

[48] See 29 U.S.C. §§1181–1191c; 26 U.S.C. §§9831(a), 9832(a)-(b). Neither ERISA nor IRC applies to governmental plans. See 29 U.S.C. §1003(b)(1); 26 U.S.C. §9831(a). ERISA also does not apply to church plans. 29 U.S.C. §1003(b)(2).

[49] See 29 U.S.C. §1132(a); 29 U.S.C. §1132(b) (limiting the Secretary of Labor's authority to take enforcement actions against health insurance issuers).

[50] 26 U.S.C. §4980D(b).

[51] 42 U.S.C. §300gg-134.

[52] 42 U.S.C. §300gg-134(a)(1).

[53] 42 U.S.C. §300gg-134(a)(2).

[54] 42 U.S.C. §300gg-134(b)(1).

prohibition on surprise billing; (2) withdraws the bill within 30 days of the violation; and (3) reimburses the plan or enrollee in an amount equal to the difference between the billed amount and the amount allowed to be billed under federal law, plus any interest at a rate determined by the HHS Secretary.[55] The HHS Secretary also may establish a hardship exemption to the penalties.[56]

The federal enforcement framework also provides mechanisms for relevant agencies to be notified of violations. Under the law, states may notify the Secretaries of HHS, Labor, and the Treasury, as applicable, of instances of provider violations of the prohibitions on surprise billing, any enforcement actions taken against providers, and the disposition of any such enforcement actions.[57] Additionally, the HHS Secretary and the Secretary of Labor must establish a process to receive complaints from consumers and ERISA plan participants, respectively, relating to alleged violations of the provider provisions.[58] The Secretary of Labor must establish a process to transmit such complaints to states or to the HHS Secretary for potential enforcement actions.[59]

Upon receiving a notice from a state or the HHS Secretary of violations of the prohibitions on surprise billing, the Secretary of Labor also must identify any patterns of such violations as they relate to plans subject to ERISA and conduct an investigation pursuant to ERISA Section 504 to determine whether any person has violated any ERISA provision.[60] In addition, the Secretary of Labor must coordinate with states and the HHS Secretary, as needed, to ensure correction of such violations retrospectively and prospectively.[61]

How Do Federal Surprise Billing Requirements Interact with State Surprise Billing Laws?

As of February 2021, more than half of the states had enacted laws to address some form of surprise billing.[62] The state policies differ in various respects but generally encompass—like the federal law—certain requirements and prohibitions on both insurers and providers.[63] To the extent these state policies apply to insurers, however, they generally do not apply to self-funded plans subject to ERISA.[64] This regulatory landscape means the federal surprise billing requirements

[55] 42 U.S.C. §300gg-134(b)(4).

[56] 42 U.S.C. §300gg-134(b)(5).

[57] 42 U.S.C. §300gg-134(a)(3).

[58] 42 U.S.C. §300gg-134(b)(4); 29 U.S.C. §1152(b).

[59] 29 U.S.C. §1152(b).

[60] 29 U.S.C. §1152(a).

[61] 29 U.S.C. §1152(a).

[62] Maanasa Kona, "State Balance Billing Protections," Commonwealth Fund, February 5, 2021, at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections.

[63] CRS Report R46116, *Surprise Billing in Private Health Insurance: Overview and Federal Policy Considerations*.

[64] Ibid. In general, ERISA broadly preempts state regulation of self-funded plans, and existing state surprise billing laws generally reflect this regulatory scheme. The relevant state surprise billing laws in Washington, for instance, specifically exclude employer-sponsored self-funded health plans from their definition of *health plans*. See RCW §§48.49.010, 48.43.005(29). However, in Rutledge v. Pharm. Care Mgmt. Assoc., 141 S. Ct. 474, 480–81 (2020), the Supreme Court recently held that certain state laws regulating health care costs—in that case, an Arkansas law that addresses reimbursement practices between pharmacy benefit managers and pharmacies—are not preempted by ERISA. Some commentators have suggested that under *Rutledge*, states may have more flexibility to apply their own surprise billing requirements to self-funded plans and their third-party administrators. See Erin C. Fuse Brown and Elizabeth Y. McCuskey, "The Implications of *Rutledge v. PCMA* for State Health Care Cost Regulation," *Health Affairs Blog*, December 17, 2020, at https://www.healthaffairs.org/do/10.1377/hblog20201216.909942/full/.

generally apply as is in two circumstances where there is an absence of relevant state law: (1) the federal law's insurer provisions apply uniformly to self-funded plans, which state law generally does not regulate, and (2) both the federal law's insurer and provider provisions apply in states that choose not to enact their own surprise billing laws.

In cases where a state maintains surprise billing requirements, the interaction of federal and state requirements may be governed by principles of federal preemption. In general, under the Constitution's Supremacy Clause, federal law preempts—or supersedes—conflicting state law.[65] At the same time, because congressional purpose is the "ultimate touchstone" of the preemption analysis,[66] federal law can specify the scope and extent of its preemptive force through express preemption provisions.[67]

The federal surprise billing law specifies its preemptive scope in two ways. First, the law expressly preserves certain areas of state law. The insurer provisions specify that the amount fully insured plans must pay providers for certain out-of-network services will continue to be governed by state law in states that have prescribed a payment methodology.[68] The law also specifies that its requirements on maintaining accurate, up-to-date provider directories do not preempt any state law relating to health care provider directories.[69]

Second, and more generally, the federal law adopts, or applies a provision similar to, the preemption provision under Section 2724(a) of the PHSA.[70] Under the federal surprise billing preemption provisions, state laws are preempted by the federal law only if the state laws impose "such standard or requirement" (in the case of fully insured plans) or "such requirement or prohibition" (in the case of providers) that "prevents the application" of a federal requirement or prohibition.[71] This generally means that federal provisions set the floor on surprise billing regulation, and existing state laws—to the extent they impose the same or *additional* standards, requirements, or prohibitions on fully insured plans and providers as the federal law—are generally preserved, *unless* the additional standards, requirements, or prohibitions "prevent[] the application" of a federal provision.[72] Few courts have interpreted this preemption language, which may be susceptible to different constructions as to its scope.

This preemption language, for instance, may be construed narrowly to generally permit state laws that are more protective of consumers. The conference report accompanying the Health Insurance Portability and Accountability Act of 1996 (HIPAA, P.L. 104-191), which enacted PHSA Section 2724(a) and related preemption provisions, could support this construction. Regarding these preemption provisions, the conferees stated they "intend[ed] the narrowest preemption," such that

[65] U.S. CONST. art. VI, cl. 2. For more information about federal preemption, see CRS Report R45825, *Federal Preemption: A Legal Primer*.

[66] Wyeth v. Levine, 555 U.S. 555, 565 (2009) (quoting Retail Clerks v. Schermerhorn, 375 U.S. 96, 103 (1963)).

[67] See Puerto Rico v. Franklin Cal. Tax-Free Trust, 136 S. Ct. 1938, 1946 (2016) (explaining that where a statute includes an express preemption clause, the Supreme Court "do[es] not invoke any presumption against pre-emption but instead focus[es] on the plain wording of the clause, which necessarily contains the best evidence of Congress' pre-emptive intent").

[68] 42 U.S.C. §§300gg-111(a)(3)(K), 300gg-111(b)(1)(D).

[69] 42 U.S.C. §300gg-115(a)(7).

[70] See 42 U.S.C. §300gg-23(a).

[71] 42 U.S.C. §300gg-23(a); §300gg-134(c) (stating that the federal surprise billing law's provider requirements "shall not be construed to supersede any provision of State law which establishes, implements, or continues in effect any requirement or prohibition except to the extent that such requirement or prohibition prevents the application of a requirement or prohibition" of the federal surprise billing requirements).

[72] See UnitedHealthcare of N.Y., Inc. v. Lacewell, 967 F.3d 82, 92 (2d Cir. 2020).

"[s]tate laws which are broader than federal requirements would not prevent the application of federal requirements."[73] As an example, the conferees noted that while HIPAA's guaranteed availability requirement would apply only in the small-group market, such that each insurer offering health insurance coverage in that market must accept every small employer with 2 to 50 employees in the state that applied for coverage and must accept for enrollment under such coverage every eligible individual who applied for enrollment, states may require guaranteed availability of coverage for groups of more than 50 employees, or for groups of 1. Based on these remarks, a few courts have commented that relevant terms of these preemption provisions "appear to permit state laws that are, generally speaking, more favorable to [consumers]."[74]

The relevant preemption language and conference report remarks, however, also could be viewed as consistent with a broader construction. Under such a construction, while more consumer-protective state provisions would be permitted, they could be preempted as "preventing the application" of federal law to the extent compliance with such a state provision would make it impossible to comply with a federal provision or would interfere with the method by which the federal statute was designed to achieve its policy goal.[75]

The potentially different interpretations of the preemption language may be particularly relevant for some federal surprise billing requirements. For example, as identified above in **Table 4**, the federal provider provisions prohibit out-of-network providers from billing patients more than in-network cost-sharing amounts for certain ancillary services delivered at or ordered from an in-network facility but permit the providers to balance bill patients for non-ancillary services if the providers satisfy certain notice-and-consent requirements.[76] Under the notice-and-consent process, an out-of-network provider generally must provide, at least 72 hours before the date of service, a written notice to the patient that provides various information, including the provider's out-of-network status, a good-faith estimate of the amount the provider may charge the patient, and a list of in-network providers at the facility that could provide the service.[77] The consent signed by patients must acknowledge that they have been provided with the written notice and were informed that payment of any billed charges may not accrue toward their plan deductibles or any limits on cost sharing.[78]

Many state surprise billing laws include comparable notice-and-consent requirements. For some of these state provisions, their interaction with federal provisions is likely the same under both interpretations of the preemption language discussed above. For instance, where the state provisions are coextensive with the federal provisions, or impose additional requirements that do not interfere with the federal provisions, the state provisions likely are *preserved* under both constructions. Some state laws, for instance, include certain additional specifications or procedures for the notice-and-consent process to protect consumers, such as prohibiting the notice

[73] See H.R. Conf. Rep. No. 104-736 (1996), at 205.

[74] See Fossen v. Blue Cross & Blue Shield of Mont., Inc., 660 F.3d 1102, 1108 (9th Cir. 2011) (internal quotation marks omitted).

[75] See UnitedHealthcare of N.Y., Inc. v. Lacewell, 967 F.3d 82, 92 (2d Cir. 2020). In *Lacewell*, the court did not specifically interpret what it means for a state law to "prevent[] the application" of ACA provisions but indicated that general implied preemption principles may inform this preemption provision's scope. Under such principles, state and federal law conflict with one another when "the two acts cannot be reconciled or consistently stand together" or if the state law "interferes with the *methods* by which the federal statute was designed to reach [its policy] goal." Ibid. at 92, 96.

[76] 42 U.S.C. §300gg-132(d).

[77] 42 U.S.C. §300gg-132(d)(2).

[78] 42 U.S.C. §300gg-132(d)(3).

from being obtained by representatives of the in-network facility or prohibiting the provider from collecting more than the estimated amount without obtaining a separate written consent.[79] State provisions that offer *less* protection to consumers, by contrast, likely are *preempted* under both constructions. State laws that allow notice to be given less than 72 hours before the date of service,[80] for instance, likely "prevent the application" of federal minimum timing requirements. Similarly, state laws that more broadly allow providers to balance bill for ancillary services if the providers follow specified notice-and-consent procedures likely "prevent the application" of the federal prohibition.[81]

Some state provisions that are more protective of consumers, however, might "prevent the application" of the federal provisions only under a broader construction of the preemption language. For example, state laws that more broadly prohibit balance billing for out-of-network services beyond ancillary services likely are considered more protective of consumers and thus likely are preserved under a narrow construction. However, such state provisions, to the extent they apply to non-ancillary services, may "prevent the application" of the federal notice-and-consent requirements by prohibiting what the federal provisions permit.[82] Thus, under a broader construction of the preemption language, such state prohibitions might be preempted as they apply to non-ancillary services because they conflict with the federal notice-and-consent process.[83]

HHS may further specify the federal surprise billing law's preemptive scope through regulations.[84]

[79] See, for instance, Cal. Health & Safety Code §1371.9(c)(2).

[80] See, for instance, Cal. Health & Safety Code §1371.9(c)(1).

[81] See, for instance, Cal. Health & Safety Code §1371.9(c).

[82] Washington State, for instance, prohibits balance billing for any nonemergency services involving "surgical or ancillary services" furnished by an out-of-network provider at an in-network facility. See RCW §48.49.020(b). Depending on the scope of "ancillary services" further specified by HHS through regulations, Washington's prohibition could be broader than the federal law. See 42 U.S.C. §300gg-132(b)(2).

[83] In Barnett Bank of Marion Cty., N.A. v. Nelson, 517 U.S. 25, 31, 33 (1996), for instance, the Supreme Court concluded, under general implied preemption principles, that a federal statute authorizing national banks to sell insurance in small towns preempted a state statute that forbade them to do so, given that the Supreme Court's precedents generally take the view that "normally Congress would not want States to forbid, or impair significantly, the exercise of a power that Congress explicitly granted."

[84] See 42 U.S.C. §300gg-132(b).

Appendix A. Implementation Requirements of the Surprise Billing Protections in the No Surprises Act

This appendix contains a table of CRS-identified deadlines and deliverables included in the No Surprises Act (Title I of Division BB of the Consolidated Appropriations Act, 2021 [P.L. 116-260]). The table includes four columns: (1) the required activity; (2) the deadline for such activity (if applicable); (3) the citation within the legislative text, including the page number; and (4) the statutory citation of the required activity (if applicable). The requirements in the table are listed in the order of their presence in the No Surprises Act. In some instances, requirements are mirrored across some combination of the Public Health Service Act (PHSA), Employee Retirement Income Security Act of 1974 (ERISA), and Internal Revenue Code (IRC). For items mirrored across statutes, CRS combined the mirrored requirements into one row in the table and included statutory citations for the mirrored language.

The table includes the provisions that require secretarial activity (including, but not limited to, federal rulemaking, public reporting, and reporting to Congress) and similar activity by other government entities (e.g., comptroller general). Anytime a Secretary (or other government entity) is required to do something relating to the implementation of a provision, CRS noted the required activity in the table below. Instances where permissive authority was provided in regard to the implementation of a provision are excluded from the table. Enforcement provisions are similarly excluded.

Some provisions include explicit deadlines for secretarial activity. For example, Section 103 of the No Surprises Act requires the Secretary of Health and Human Services (HHS), the Secretary of Labor, and the Secretary of the Treasury to establish, through rulemaking, an independent dispute resolution process no later than one year after the date of enactment (i.e., one year after December 27, 2020). When explicit deadlines are included within the legislative text, these deadlines are noted within each row. Other provisions call for the federal government to take some action but do not mention an explicit timing. For example, Section 104 of the No Surprises Act requires the HHS Secretary to, through rulemaking, establish a process to receive specified consumer complaints but does not mention a timing element for when the rulemaking needs to be issued. Where the provisions did not mention explicit timing, the deadline column indicates "No specified deadline."

Table A-1. Deadlines and Deliverables in the No Surprises Act

(Title I of Division BB of the Consolidated Appropriations Act, 2021 [P.L. 116-260])

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
Section 102. Health Insurance Requirements Regarding Surprise Medical Billing			
The Secretaries of HHS and the Treasury, in consultation with Secretary of Labor, are required to establish through rulemaking a process under which health plans and issuers are audited by the Secretary of HHS, the Secretary of the Treasury, or an applicable state authority. The audit's purpose is to ensure that such plans and coverage comply with the requirement to apply a qualifying payment amount when making a payment for certain items and services.	Not later than October 1, 2021	Section 102(a) [1579] Section 102(c) [1605]	PHSA Section 2799A-1(a)(2)(A)(i) IRC Section 9816(a)(2)(A)(i)
The Secretaries of HHS and the Treasury are required to conduct audits of a sample of claims data from up to 25 health plans and issuers annually.	Annual basis beginning with 2022	Section 102(a) [1579] Section 102(c) [1605]	PHSA Section 2799A-1(a)(2)(A)(ii) IRC Section 9816(a)(2)(A)(ii)(I)
The Secretaries of HHS and the Treasury are required to annually submit to Congress reports on the number of plans and issuers that were audited during such year.	Annual basis beginning with 2022	Section 102(a) [1580] Section 102(c) [1605]	PHSA Section 2799A-1(a)(2)(A)(iii) IRC Section 9816(a)(2)(A)(iii)
The Secretaries of HHS, Labor, and the Treasury are required to establish through rulemaking (1) the methodology that health plans and issuers are required to use to determine the qualifying payment amount; (2) the information that such plans or issuers are required to share with a nonparticipating provider or facility, as applicable, when making such a determination; (3) the geographic regions applied to determine the qualifying payment amount; and (4) a process to receive complaints of violations of the audit requirements related to qualifying payment amounts.	Not later than July 1, 2021	Section 102(a) [1580] Section 102(b) [1593] Section 102(c) [1605]	PHSA Section 2799A-1(a)(2)(B) ERISA Section 716(a)(2) IRC Section 9816(a)(2)(B)
The Secretaries of HHS, Labor, and the Treasury are required to issue guidelines pursuant to rulemaking that address the health condition that an individual is	No specified deadline	Section 102(a) [1582] Section 102(b) [1595] Section 102(c) [1607]	PHSA Section 2799A-1(a)(3)(C)(ii)((II)(cc) ERISA Section 716(a)(3)(C)(ii)(II)(cc) IRC Section 9816(a)(3)(C)(ii)(II)(cc)

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
required to be in to receive notice and to provide informed consent regarding emergency services.			
The Secretaries of HHS, Labor, and the Treasury are required to establish a methodology for determining the qualifying payment amount for the first year during which new plans and coverage are offered by health plans and issuers that did not offer any coverage in a geographic area during 2019.	No specified deadline	Section 102(a) [1583] Section 102(b) [1596] Section 102(c) [1608]	PHSA Section 2799A-1(a)(3)(E)(ii) ERISA Section 716(a)(3)(E)(ii) IRC Section 9816(a)(3)(E)(ii)
Section 103. Determination of Out-of-Network Rates to Be Paid by Health Plans; Independent Dispute Resolution Process			
The Secretaries of HHS, Labor, and the Treasury are required to specify the information within the IDR process initiation notice that is required to be sent by the party seeking to initiate the IDR process to the other party and the Secretaries.	No specified deadline	Section 103(a) [1617] Section 103(b) [1626] Section 103(c) [1635]	PHSA Section 2799A-1(c)(1)(B) ERISA Section 716(c)(1)(B) IRC Section 9816(c)(1)(B)
The Secretaries of HHS, Labor, and the Treasury are required to jointly establish by regulation a single IDR process under which a certified IDR entity determines the amount for specified surprise billing items or services.	Not later than one year after enactment of the subsection (i.e., December 27, 2021)	Section 103(a) [1617] Section 103(b) [1626] Section 103(c) [1635]	PHSA Section 2799A-1(c)(2)(A) ERISA Section 716(c)(2)(A) IRC Section 9816(c)(2)(A)
Under the IDR process, the Secretaries of HHS, Labor, and the Treasury are required to specify the criteria under which multiple IDR dispute items can be considered jointly as part of a batch.	No specified deadline	Section 103(a) [1618] Section 103(b) [1627] Section 103(c) [1635]	PHSA Section 2799A-1(c)(3) ERISA Section 716(c)(3) IRC Section 9816(c)(3)
The Secretaries of HHS, Labor, and the Treasury are required to establish a process to certify (including to recertify) entities as IDR entities.	No specified deadline	Section 103(a) [1619] Section 103(b) [1627] Section 103(c) [1636]	PHSA Section 2799A-1(c)(4)(A) ERISA Section 716(c)(4)(A) IRC Section 9816(c)(4)(A)
The Secretaries of HHS, Labor, and the Treasury are required to promulgate regulations that specify how a certified IDR entity is required to maintain confidentiality of individually identifiable health information in the course of conducting an IDR determination.	No specified deadline	Section 103(a) [1619] Section 103(b) [1628] Section 103(c) [1636]	PHSA Section 2799A-1(c)(4)(A)(v) ERISA Section 716(c)(4)(A)(v) IRC Section 9816(c)(4)(A)(v)

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
The Secretaries of HHS, Labor, and the Treasury are required to establish a method for the selection of a certified IDR entity by the parties involved in the IDR process.	No specified deadline	Section 103(a) [1620] Section 103(b) [1628] Section 103(c) [1637]	PHSA Section 2799A-1(c)(4)(F) ERISA Section 716(c)(4)(F) IRC Section 9816(c)(4)(F)
The Secretaries of HHS, Labor, and the Treasury are required to specify a process for determining that a certified IDR entity does not have a conflict of interest with a party subject to the determination of the amount of payment for an item or service.	No specified deadline	Section 103(a) [1620] Section 103(b) [1629] Section 103(c) [1637]	PHSA Section 2799A-1(c)(4)(F)(i)(III) ERISA Section 716(c)(4)(F)(i)(III) IRC Section 9816(c)(4)(F)(i)(III)
There is a requirement to suspend subsequent IDR requests 90 days following an initial determination if the subsequent IDR requests involve the same parties and an item or service that was the subject of the initial determination. The Secretaries of HHS, Labor, and the Treasury are required to examine and submit to Congress a report on the impact of the requirement.	**Interim Report:** Not later than two years from implementation of the IDR process (i.e., December 27, 2023) **Final Report:** Not later than four years from implementation of the IDR process (i.e., December 27, 2025)	Section 103(a) [1623] Section 103(b) [1631] Section 103(c) [1640]	PHSA Section 2799A-1(c)(5)(E)(iv) ERISA Section 716(c)(5)(E)(iv) IRC Section 9816(c)(5)(E)(iv)
The Secretaries of HHS, Labor, and the Treasury are required to make publicly available on the corresponding department's website data regarding the IDR process, including, for each calendar quarter, (1) the number of times the IDR process was initiated and a payment determination was made by a certified IDR entity, (2) the size of the provider practices and facilities using the IDR process, (3) the number of times the payment determination exceeded the qualifying payment amount, (4) the amount of expenditures made by the Secretaries in carrying out the IDR process, (5) the amount of IDR process administrative fees paid, and (6) the total amount of compensation paid to certified IDR entities.	Each calendar quarter in 2022 and each calendar quarter in each subsequent year	Section 103(a) [1623] Section 103(b) [1632] Section 103(c) [1641]	PHSA Section 2799A-1(c)(7)(A) ERISA Section 716(c)(7)(A) IRC Section 9816(c)(7)(A)

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
The Secretaries of HHS, Labor, and the Treasury are required to specify what information an IDR entity is required to submit to each Secretary as a condition of IDR entity certification.	No specified deadline	Section 103(a) [1624] Section 103(b) [1633] Section 103(c) [1642]	PHSA Section 2799A-1(c)(7)(C) ERISA Section 716(c)(7)(C) IRC Section 9816(c)(7)(C)
The Secretaries of HHS, Labor, and the Treasury are required to specify the time and manner in which the IDR administrative fee is required to be paid to the Secretaries.	No specified deadline	Section 103(a) [1625] Section 103(b) [1633] Section 103(c) [1642]	PHSA Section 2799A-1(c)(8)(A) ERISA Section 716(c)(8)(A) IRC Section 9816(c)(8)(A)
The Secretaries of HHS, Labor, and the Treasury are required to annually specify the amount of the IDR administrative fee.	Annually	Section 103(a) [1625] Section 103(b) [1634] Section 103(c) [1642]	PHSA Section 2799A-1(c)(8)(B) ERISA Section 716(c)(8)(B) IRC Section 9816(c)(8)(B)
Section 104. Health Care Provider Requirements Regarding Surprise Billing			
The HHS Secretary is required to specify other items and services provided by specialty practitioners that are considered ancillary services subject to balance billing protections for consumers.	No specified deadline	Section 104(a) [1644]	PHSA Section 2799B-2(b)(1)(C)
The HHS Secretary is required to issue guidance (which is to be updated as determined necessary by the Secretary) on the advance notice that is required to be provided to an individual prior to being treated by a nonparticipating provider or at a nonparticipating facility.	Not later than July 1, 2021	Section 104(a) [1645]	PHSA 2799B-2(d)(1)(A)
The HHS Secretary, in consultation with the Secretary of Labor, is required to specify, through guidance, the consent document for individuals seeking to receive services from a nonparticipating provider or nonparticipating facility.	No specified deadline	Section 104(a) [1646]	PHSA 2799B-2(d)(3)
The HHS Secretary is required, through rulemaking, to establish a process to receive consumer complaints of violations of specified provider surprise billing requirements.	No specified deadline	Section 104(a) [1649]	PHSA 2799B-4(b)(3)

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
The Secretary of Labor is required to ensure a process that allows the Secretary to receive complaints from private health insurance enrollees regarding violations of specified provider surprise billing requirements and to transmit such complaints to states or the HHS Secretary for potential enforcement.	Not later than January 1, 2022	Section 104(b) [1650]	ERISA Section 522(b)
Section 105. End Surprise Air Ambulance Bills			
The Secretaries of HHS, Labor, and the Treasury are required to specify the information within the air ambulance IDR process initiation notice.	No specified deadline	Section 105(a)(1) [1651] Section 105(a)(2)(A) [1658] Section 105(a)(3)(A) [1665]	PHSA Section 2799A-2(b)(1)(B) ERISA Section 717(b)(1)(B) IRC Section 9817(b)(1)(B)
The Secretaries of HHS, Labor, and the Treasury are required to jointly establish by regulation a single IDR process for air ambulance services.	Not later than one year after enactment of the subsection (i.e., December 27, 2021)	Section 105(a)(1) [1652] Section 105(a)(2)(A) [1658] Section 105(a)(3)(A) [1665]	PHSA Section 2799A-2(b)(2)(A) ERISA Section 717(b)(2)(A) IRC Section 9817(b)(2)(A)
The Secretaries of HHS, Labor, and the Treasury are required to publish on the public website of their respective departments specified data regarding the air ambulance IDR process.	Each calendar quarter in 2022 and each calendar quarter in a subsequent year	Section 105(a)(1) [1655] Section 105(a)(2)(A) [1662] Section 105(a)(3)(A) [1668]	PHSA Section 2799A-2(b)(7)(A) ERISA Section 717(b)(7)(A) IRC Section 9817(b)(7)(A)
The Secretaries of HHS, Labor, and the Treasury are required to specify the time and manner in which the air ambulance IDR process administrative fee must be paid to the Secretaries.	No specified deadline	Section 105(a)(1) [1656] Section 105(a)(2)(A) [1663] Section 105(a)(3)(A) [1669]	PHSA Section 2799A-2(b)(8)(A) ERISA Section 717(b)(8)(A) IRC 9817(b)(8)(A)
The Secretaries of HHS, Labor, and the Treasury are required to annually specify the amount of the air ambulance IDR process administrative fee.	Annually	Section 105(a)(1) [1656] Section 105(a)(2)(A) [1663] Section 105(a)(3)(A) [1669]	PHSA Section 2799A-2(b)(8)(B) ERISA Section 717(b)(8)(B) IRC Section 9817(b)(8)(B)
Section 106. Reporting Requirements Regarding Air Ambulance Services			
The HHS Secretary, in consultation with the Secretary of Transportation, is required to develop and make publicly available a comprehensive report summarizing specified air ambulance data submitted by air ambulance providers and plans and issuers, including claims data.	Not later than March 31, 2025	Section 106(c)(1) [1674]	Not applicable

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
The HHS Secretary, in consultation with the Secretary of Transportation, is required, through notice and comment rulemaking, to specify the form and manner in which air ambulance service reporting is to be submitted. This includes reporting by air ambulance providers to the Secretaries of HHS and Transportation, as well as reporting by plans and issuers to the Secretaries of HHS, Labor, and the Treasury.	Not later than one year after enactment of the act (i.e., December 27, 2021)	Section 106(d) [1675]	Not applicable
The Secretaries of HHS and Transportation are required to establish an Advisory Committee on Air Ambulance Quality and Patient Safety.	Not later than 60 days after enactment of the act (i.e., February 25, 2021)	Section 106(g)(1) [1676]	Not applicable
The Advisory Committee on Air Ambulance Quality and Patient Safety is required to hold its first meeting.	Not later than 90 days after enactment of the act (i.e., March 27, 2021)	Section 106(g)(3) [1676]	Not applicable
The Advisory Committee on Air Ambulance Quality and Patient Safety, in consultation with experts and stakeholders, is required to develop and make publicly available a report on recommendations on specified aspects of air ambulance services.	Not later than 180 days after the first meeting of the Advisory Committee on Air Ambulance Quality and Patient Safety (i.e., not later than September 23, 2021)	Section 106(g)(5) [1677]	Not applicable
Section 108. Implementing Protections Against Provider Discrimination			
The Secretaries of HHS, Labor, and the Treasury are required to issue a rule implementing the protections regarding nondiscrimination in health care in PHSA Section 2706(a). These protections prevent health plans and issuers from discriminating with respect to provider network participation against any health care provider that is acting within the scope of that provider's license or certification under applicable state law.	**Proposed Rule:** Not later than January 1, 2022 (the Secretaries are required to consider public comments for 60 days after issuance) **Final Rule:** Not later than six months after the conclusion of the 60-day comment period that begins after issuance of the proposed rule (i.e., September 2, 2022)	Section 108 [1678]	Not applicable

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
Section 109. Reports			
The HHS Secretary, in consultation with the Federal Trade Commission and the attorney general, is required to conduct a study on the effects of the surprise billing provisions in the No Surprises Act.	Not later than January 1, 2023, and annually thereafter for four years	Section 109(a)(1) [1678]	Not applicable
The HHS Secretary, in consultation with the Federal Trade Commission and the attorney general, is required to submit a report on the study regarding the effects of the surprise billing provisions in the No Surprises Act. As part of this report, the HHS Secretary, in consultation with the Secretaries of Labor and the Treasury, is required to make recommendations for the effective enforcement of requirements related to health plan or issuer payment for emergency and applicable nonemergency services, including with respect to potential challenges to addressing anticompetitive consolidation.	Not later than January 1, 2023, and annually thereafter for four years	Section 109(a)(2) and (3) [1679]	Not applicable
The comptroller general is required to submit to Congress a report summarizing the effects of the surprise billing provisions in the No Surprises Act on changes in health plan and issuer provider networks, in fee schedules and amounts for health care services, and to contracted rates.	Not later than January 1, 2025	Section 109(b) [1679]	Not applicable
The comptroller general is required to submit to Congress, and make publicly available, a report on the adequacy of provider networks, including legislative recommendations to improve the adequacy of such networks.	Not later than January 1, 2023	Section 109(c) [1680]	Not applicable
The comptroller general is required to conduct a study and submit to Congress a report on the IDR process, including an analysis of potential financial relationships between providers and facilities that use the IDR process and private equity firms.	Not later than December 31, 2023	Section 109(d) [1680]	Not applicable

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
Section 112. Patient Protections Through Transparency and Patient-Provider Dispute Resolution			
The HHS Secretary is required to establish a patient-provider dispute resolution process under which an uninsured individual who was billed substantially more than a good-faith estimate for an item or service may seek a determination from an entity regarding the charges to be paid by the uninsured individual.	Not later than January 1, 2022	Section 112 [1686]	PHSA Section 2799B-7(a)
Under the patient-provider dispute resolution process, the HHS Secretary is required to provide for a method to select an entity, including conflict of interest standards, and to provide notice to the uninsured individual and the applicable provider or facility that is party to the determination.	No specified deadline	Section 112 [1686]	PHSA Section 2799B-7(b)
The HHS Secretary is required to establish a fee to participate in the patient-provider dispute resolution process in such a manner as to not create a barrier to an uninsured individual's access to the process.	No specified deadline	Section 112 [1687]	PHSA Section 2799B-7(c)
The HHS Secretary is required to establish or recognize a process to certify entities for the patient-provider dispute resolution process.	No specified deadline	Section 112 [1687]	PHSA Section 2799B-7(d)
Section 115. State All-Payer Claims Databases			
The HHS Secretary is required to make one-time grants to eligible states to establish or improve a state all-payer claims database.	No specified deadline	Section 115(a) [1694]	PHSA Section 320B(a)
The HHS Secretary is required to specify the timing, manner, and contents of an application for states to apply for grants to establish a new or improve an existing state all-payer claims database.	No specified deadline	Section 115(a) [1694]	PHSA Section 320B(c)
The Secretary of Labor is required to establish (and periodically update) a standardized reporting format for the voluntary reporting of group health plans to state all-payer claims databases. The Secretary of Labor is	Not later than one year after enactment of the section (i.e., December 27, 2021) and periodically thereafter	Section 115(b) [1696]	ERISA Section 735(a)

Requirement	Deadline	Legislative Citation [Page Number]	Statutory Citation
also required to provide guidance to states on collecting such data.			
The Secretary of Labor is required to appoint and convene an Advisory Committee to advise the Secretary of Labor regarding the reporting format and guidance for the voluntary reporting of group health plans data to state all-payer claims databases.	Not later than 90 days after enactment of the section (i.e., March 27, 2021)	Section 115(b) [1696]	ERISA Section 735(b)
The Advisory Committee is required to report, to the Secretary of Labor and to Congress, recommendations on the establishment of the format and guidance for the voluntary reporting of group health plan data to state all-payer claims databases.	Not later than 180 days after enactment of the section (i.e., June 25, 2021)	Section 115(b) [1697]	ERISA Section 735(b)(3)
Section 117. Advisory Committee on Ground Ambulance and Patient Billing			
The Secretaries of HHS, Labor, and the Treasury are required to jointly establish an Advisory Committee on Ground Ambulance and Patient Billing.	Not later than 90 days after enactment of the act (i.e., March 27, 2021)	Section 117(a) [1707]	Not applicable
The Advisory Committee on Ground Ambulance and Patient Billing is required to submit a report containing specific recommendations to the Secretaries of HHS, Labor, and the Treasury and to Congress.	Not later than 180 days after the date of the first meeting of the Advisory Committee on Ground Ambulance and Patient Billing	Section 117(e) [1708]	Not applicable
Section 118. Implementation Funding			
The Secretaries of HHS, Labor, and the Treasury are each required to submit to Congress a report on funds expended pursuant to the funds appropriated to carry out the implementation aspects of Title I (the No Surprises Act) and Title II of Division BB of the Consolidated Appropriations Act, 2021 (P.L. 116-260).	Annually	Section 118(c) [1709]	Not applicable

Source: Congressional Research Service analysis of the No Surprises Act (Title I of Division BB of the Consolidated Appropriations Act, 2021 [P.L. 116-260]), at https://www.congress.gov/116/bills/hr133/BILLS-116hr133enr.pdf.

Notes: ERISA = Employee Retirement Income Security Act of 1974; HHS = U.S. Department of Health and Human Services; IDR = independent dispute resolution; IRC = Internal Revenue Code; PHSA = Public Health Service Act. Unless otherwise indicated, *health plans and issuers* refers to group health plans and health insurance issuers

offering group or individual health insurance coverage. For requirements that state "No specified deadline," it means the provision containing the requirement did not specify an explicit deadline.

Appendix B. Other Provisions of the No Surprises Act

Federal surprise billing requirements were established as part of the No Surprises Act, which was included as Title I of Division BB of the Consolidated Appropriations Act, 2021 (P.L. 116-260). The No Surprises Act also included other provisions that relate to the topic of surprise billing but do not directly relate to the requirements on insurers and providers regarding the cost of, and payment for, services provided in surprise billing situations. Some of these other provisions that have not been discussed or referenced in the body of this report are summarized below, by topic area in alphabetical order.[85]

Air Ambulance Reporting Requirements

The No Surprises Act required insurers and providers to submit information on air ambulance services to the federal government.

Requirements on Insurers

The act required insurers to report specified information to the Secretaries of Health and Human Services (HHS), Labor, and the Treasury for two consecutive years.[86] The first year of this requirement applies to plan years occurring during the first calendar year that begins after the HHS Secretary, in consultation with the Secretary of Transportation, issues rules regarding the air ambulance reporting requirements.

Requirements on Providers

The act required air ambulance providers to report specified information to the Secretaries of HHS and Transportation for two consecutive years.[87] The Secretary of Transportation may use this information to determine whether air ambulance providers have engaged in unfair and deceptive practices and methods of competition.[88] The first year of this requirement applies to plan years occurring during the first calendar year that begins after the HHS Secretary, in consultation with the Secretary of Transportation, issues rules regarding the air ambulance reporting requirements.

All-Payer Claims Databases

The No Surprises Act established a grant program to help states create or improve all-payer claims databases.[89] Grants awarded under the program would be for $2.5 million and would be available to the state for three years. (Portions of the grant awards would be distributed to the states in each year.) Once the database is established, non-state entities would be allowed to

[85] Federal government reporting and publication requirements and other implementation-related provisions are not discussed in this appendix but generally can be found in **Table A-1**.

[86] 42 U.S.C. §300gg-118.

[87] §106(a), Title I of Division BB of P.L. 116-260.

[88] §106(f), Title I of Division BB of P.L. 116-260.

[89] An all-payer claims database is a large-scale database that collects health care claims from a variety of providers and payers. 42 U.S.C. §247d-11.

request access to all-payer claims database data for specified purposes (e.g., research, quality improvement, cost containment).

To be eligible for grant funding under this program, states must submit an application to the HHS Secretary.[90] As part of this application, states must indicate how they will ensure uniform data collection and the privacy and security of the data.

The No Surprises Act authorized the appropriation of $50 million for each of FY2022 and FY2023 and $25 million for FY2024. Amounts are authorized to remain available until expended.

Appropriations

The No Surprises Act included $500 million in appropriations for FY2021 through FY2024.[91] The funds were appropriated to the Secretaries of HHS, Labor, and the Treasury for specified implementation purposes regarding the No Surprises Act and Title II of Division BB of the Consolidated Appropriations Act, 2021 (P.L. 116-260).

External Review Process in Cases of Certain Surprise Medical Bills

The No Surprises Act required insurers to implement an external review process for coverage determinations and claims.[92] The external review process must meet applicable state or federal standards.

The No Surprises Act specified that the external review process applies to any adverse determinations made by insurers with respect to specified surprise billing situations (including whether a specific service is a surprise billing service).[93] This requirement will apply not later than January 1, 2022.

General Informational Requirements to Assist Consumers

The No Surprises Act imposed requirements on insurers and providers regarding the provision of various pieces of information to consumers. These requirements were in addition to the informational protections that are directly related to specific surprise billing situations (see "Informational Protections") and are more general in nature.

Requirements on Insurers

The act required insurers to make publicly available, post on a website, and include in each plan an explanation of benefits, information on federal balance billing prohibitions in certain surprise billing situations, applicable state law balance billing prohibitions, and specified surprise billing

[90] The HHS Secretary is allowed to prioritize applications that indicate a willingness to work with other states to establish a single application for data access or indicate that a specific self-insured group health plan reporting format will be implemented.

[91] §118, Title I of Division BB of P.L. 116-260.

[92] 42 U.S.C. §300gg-19(b).

[93] Specified surprise billing situations include out-of-network emergency services; out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; out-of-network nonemergency, non-ancillary services provided at an in-network facility; out-of-network nonemergency, ancillary services provided at an in-network facility; out-of-network air ambulance services; and services scheduled at least three business days in advance. §110(a), Title I of Division BB of P.L. 116-260.

requirements.[94] In addition, it required insurers to include information on contacting appropriate state and federal agencies if a consumer believes a provider has violated any of the aforementioned requirements. This requirement will apply to plan years beginning on or after January 1, 2022.

The No Surprises Act also required insurers to include the following information on any physical or electronic plan documents or insurance cards: the plan's deductible, the plan's out-of-pocket maximum, and a telephone number and website where individuals can receive consumer assistance information.[95] This requirement will apply to plan years beginning on or after January 1, 2022.

In addition, the act required insurers to maintain a price comparison tool, which consumers would be able to access via telephone and a website, to compare the amount of cost sharing they would be responsible for if they received certain services from various providers.[96] This requirement will apply to plan years beginning on or after January 1, 2022.

Requirements on Providers

The No Surprises Act required providers to make publicly available a one-page notice that provides, in clear and understandable language, information on specified surprise billing requirements.[97] In addition, the notice must contain information on which state and federal agencies consumers may contact if they believe a provider has violated such a requirement. The notice must be provided to consumers with private health insurance and posted on a public website (if applicable). This requirement will apply not later than January 1, 2022.

Health Savings Accounts and Surprise Billing Requirements

A health savings account (HSA) is a tax-advantaged account that individuals can use to pay for unreimbursed medical expenses (e.g., deductibles, co-payments, coinsurance, and services not covered by insurance).[98] Individuals are eligible to establish and contribute to an HSA if they have coverage under an HSA-qualified high-deductible health plan (HDHP), do not have disqualifying coverage, and cannot be claimed as a dependent on another person's tax return.

To be HSA qualified, a health plan must meet several tests: it must have a deductible above a certain minimum level, it must limit out-of-pocket expenditures for covered benefits to no more than a certain maximum level, and it may cover only preventive care services and (for plan years beginning on or before December 31, 2021) telehealth services before the deductible is met. If the

[94] Specified surprise billing requirements include insurer requirements in the following surprise billing situations: out-of-network emergency services; out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; out-of-network nonemergency, non-ancillary services provided at an in-network facility; out-of-network nonemergency, ancillary services provided at an in-network facility; and services scheduled at least three business days in advance. 42 U.S.C. §300gg-116(c).

[95] 42 U.S.C. §300gg-111(e).

[96] 42 U.S.C. §300gg-114.

[97] Specified surprise billing situations include out-of-network emergency services; out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; out-of-network nonemergency, non-ancillary services provided at an in-network facility; and out-of-network nonemergency, ancillary services provided at an in-network facility. 42 U.S.C §300gg-133.

[98] For more information on health savings accounts, see CRS Report R45277, *Health Savings Accounts (HSAs)*.

plan covered any other services before the deductible is met, the plan would not be considered an HSA-eligible HDHP.

The No Surprises Act allowed HSA-qualified HDHPs to cover specified surprise billing services before the deductible is met and still be considered HSA-qualified.[99] Relatedly, the act specified that individuals will not be disqualified from being HSA-eligible merely because they receive coverage of specified surprise billing services before their deductibles are met. These requirements will apply to plan years beginning on or after January 1, 2022.

[99] Specified surprise billing services include out-of-network emergency services; out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services; out-of-network nonemergency, non-ancillary services provided at an in-network facility; out-of-network nonemergency, ancillary services provided at an in-network facility; out-of-network air ambulance services; services scheduled at least three business days in advance (though insurers are not required to provide benefits in this situation, see 42 U.S.C. §300gg-111(f)); and any situations subject to state laws providing similar protections. See 26 U.S.C. §§223(c)(1)(D) and 223(c)(2)(F). §102(c)(1)(4), Title I of Division BB of P.L. 116-260.

Appendix C. Summary of the Applicability of Various Requirements in Different Surprise Billing Situations

The following table summarizes the applicability of various federal surprise billing requirements across different situations, as discussed in this report.

Table C-1. Summary of Various Federal Surprise Billing Requirements, by Situation

Situation	Consumer Financial Protections	Consumer Informational Protections	Relationship Between Financial and Information Protections	Payment Methodologies	Payment Methodology Interactions with State Laws and Agreements
Out-of-network emergency services	The cost-sharing requirements cannot be greater than what they would have been had the service been provided in-network. The cost-sharing amounts are to be calculated based on the median in-network rate for the service or plan (e.g., a 20% coinsurance rate would be based on the median in-network rate).[a] The cost-sharing amounts count toward the in-network deductible and the out-of-pocket maximum. The consumer cannot be balance billed directly by the provider.	None	Not applicable	Initial payment (or notice of denial of payment) followed by out-of-network provider or insurer option to initiate negotiation. If negotiation fails, either party may initiate an independent dispute resolution process	Federal methodology does not apply in states with an all-payer model agreement or a surprise billing law in effect with respect to the applicable plan type, provider type, and service
Out-of-network services provided to a consumer during an outpatient observation stay or an inpatient or outpatient stay during the visit in which a consumer receives emergency services		Provider notice	Notification and consent requirements must be met in order for (or as part of criteria for) consumer protections to not apply		
Out-of-network nonemergency, non-ancillary services provided at an in-network facility		Provider notice	Notification and consent requirements must be met in order for (or as part of criteria for) consumer protections to not apply		
Out-of-network nonemergency, ancillary services provided at an in-network facility		None	Not applicable		
Out-of-network air ambulance services	The cost-sharing requirements are the same as what they would have been had the service been provided in-network. The coinsurance and deductible amounts are	None	Not applicable	Initial payment (or notice of denial of payment) followed by out-of-network provider or insurer option to initiate negotiation. If negotiation fails, either party may initiate an independent	Federal methodology does not apply in states with an all-payer model agreement or a surprise billing law in effect with respect to the applicable plan type, provider type, and service[b]

Situation	Consumer Financial Protections	Consumer Informational Protections	Relationship Between Financial and Information Protections	Payment Methodologies	Payment Methodology Interactions with State Laws and Agreements
	to be calculated based on in-network rates. The cost-sharing amounts count toward the in-network deductible and the out-of-pocket maximum. The consumer cannot be balance billed directly by the provider.			dispute resolution process	
Services scheduled at least three business days in advance	None.	Insurer notice (includes information received from provider)	No financial protections associated with private health insurance surprise billing situation[c]	None specified in statute	Not applicable
Out-of-network services from a provider who initially was in network but subsequently became out of network during the course of treatment (i.e., continuity of care)	Benefits are provided under the same terms that would have applied before the change in provider network status. The consumer effectively cannot be balance billed directly by the provider.	Insurer notice	Informs the consumer of the option to elect to receive financial protections	None specified in statute	Not applicable
Out-of-network services from a provider that the consumer assumed was in network based on incorrect information from the plan (e.g., incorrect provider directory information)	The cost-sharing requirements cannot be greater than what they would have been had the service been provided in network. The cost-sharing amounts count toward the in-network deductible and	Provider directory	Consumer receives financial protections if he/she uses a provider directory (or uses a phone or electronic methods to communicate with the insurer), and receives incorrect information about the provider's network status	None specified in statute	Not applicable

Situation	Consumer Financial Protections	Consumer Informational Protections	Relationship Between Financial and Information Protections	Payment Methodologies	Payment Methodology Interactions with State Laws and Agreements
	the out-of-pocket maximum. The consumer effectively cannot be balance billed directly by the provider. Excess amounts paid by individuals for services are to be refunded, with interest.				

Source: Congressional Research Service summary of various requirements included in Parts D and E of Subchapter XXV, Part 6A, Title 42, *U.S. Code*.

Notes: Parallel requirements can be found in the Employee Retirement Income Security Act of 1974 (ERISA) and the Internal Revenue Code (IRC).

a. If the service is provided in a state that has an applicable surprise billing law or an all-payer model agreement, the cost-sharing amount is to be calculated in accordance with such law or agreement.

b. Although federal law would defer to state air ambulance surprise billing laws in specified instances, states generally have been limited in their ability to enact air ambulance surprise billing laws as a result of the Airline Deregulation Act of 1978 (P.L. 95-504), which preempts state regulation of payment rates for certain air transportation carriers (including air ambulances). For a discussion of state attempts to address air ambulance surprise billing, see Government Accountability Office, *Air Ambulance: Available Data Show Privately-Insured Patients Are at Financial Risk*, GAO-19-292, March 20, 2019, p. 19, at https://www.gao.gov/assets/700/697684.pdf.

c. The financial protections that apply to situations in which services are scheduled three days in advance vary depending on the consumer's insurance status. The financial protections do not apply to consumers with private health insurance who are submitting a claim through their plan; however, the financial protections do apply to uninsured individuals (defined as individuals who are not enrolled in a private health insurance plan, federal health care program, or Federal Employees Health Benefits Program plan and individuals who are enrolled in a private health insurance plan but are not seeking to have the scheduled service covered by their plan). Specifically, uninsured individuals in this situation would have access to a patient-provider dispute resolution process if they were charged an amount that is "substantially in excess" of an initially provided good-faith estimate of costs. Under the patient-provider dispute resolution process, an unaffiliated entity would determine the charged amount that the individual is responsible for paying. 42 U.S.C. §300gg-137.

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