No Surprises Act

Sec. 101. Short title.	• This title may be cited as the "No Surprises Act".
Sec. 102. Health insurance requirements regarding surprise medical billing.	• Requires health plans to hold patients harmless from surprise medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network emergency care, for certain ancillary services provided by out-of-network providers at in-network facilities, and for out-of-network care provided at in-network facilities without the patient's informed consent. • Requires that out-of-network surprise bills are attributed to a patient's in-network deductible. Ensures that patients are kept out of the middle of provider-plan billing disputes. While plans are required to make payment to providers, there is no upfront federally-set benchmark.
Sec. 103. Determination of out-of-network rates to be paid by health plans; Independent dispute resolution process.	• Provides for a 30-day open negotiation period for providers and issuers to settle out-of-network claims. • In the event that the parties are unable to reach a negotiated agreement, they may access a binding arbitration process – referred to as Independent Dispute Resolution (IDR) – in which one offer prevails. Providers may batch similar services in one proceeding when claims are from the same issuer. • The IDR process will be administered by independent, unbiased entities with no affiliation to providers or issuers. • The IDR entity is required to consider the median in-network rate, alongside relevant information brought by either party, information requested by the reviewer, as well as factors such as the provider's training and experience, patient acuity and the complexity of furnishing the item or service, in the case of a provider that is a facility, the teaching status, case mix and scope of services of such facility, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, prior contracted rates during the previous four plan years, and other items.. • Following IDR, the party that initiated the IDR may not take the same party to IDR for the same item or service for 90 days following a determination by the IDR entity, in order to encourage settlement of similar claims, but all claims that occur during that 90-day period may still be eligible for IDR upon completion of the 90-day period.

Sec. 104. Health care provider requirements regarding surprise medical billing.	• Prohibits out-of-network facilities and providers from sending patients balance bills for more than the in-network cost-sharing amount, in the surprise billing circumstances defined in Sec. 102. • Prohibits certain out-of-network providers from balance billing patients unless the provider gives the patient notice of their network status and an estimate of charges 72 hours prior to receiving out-of-network services and the patient provides consent to receive out-of-network care. In the case of appointments made within 72 hours of receiving services, the patient must receive the notice the day the appointment is made and consent to receive out-of-network care.
Sec. 105. Ending surprise air ambulance bills.	• Patients are held harmless from surprise air ambulance medical bills. Patients are only required to pay the in-network cost-sharing amount for out-of-network air ambulances (including attributing the bill to the in-network deductible). Air ambulances are barred from sending patients balance bills for more than the in-network cost-sharing amount. • Provides for a 30-day open negotiation period for air ambulance providers and issuers to settle out-of-network claims. • In the event that the parties are unable to reach a negotiated agreement, they may access a baseball-style, binding arbitration – referred to as Independent Dispute Resolution (IDR). • If a bill goes to IDR, the IDR entity is required to consider the market-based median in-network rate, as well as information brought by the parties related to the training, experience, and quality of the provider, location where the patient was picked up and the population density of that location, the air ambulance vehicle type and medical capabilities, extenuating factors such as patient acuity and the complexity of furnishing the item or service, demonstrations of good faith efforts (or lack of good faith efforts) to enter into a network agreement, prior contracted rates during the previous four plan years, or other information submitted by the parties.
Sec. 106. Reporting requirements regarding air ambulance services.	• Requires air ambulance providers to submit two years of cost data to the Secretaries of HHS and Transportation and insurers to submit two years of claims data related to air ambulance services to the Secretary of HHS. Requires the Secretaries to publish a comprehensive report on the cost and claims data submitted. • Establishes an advisory committee on air ambulance quality and patient safety.
Sec. 107. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations.	• A group or individual health plan shall include on their plan or insurance identification card issued to the enrollee the amount of the in-network and out-of-network deductibles and the in-network and out-of-network out-of-pocket maximum limitations.

Sec. 108. Implementing protections against provider discrimination.	• Requires the Secretaries of HHS, Labor, and Treasury to promulgate a rule within six months of enactment implementing protections against provider discrimination.
Sec. 109. Reports.	• Requires the Secretary of HHS, in consultation with the Federal Trade Commission and Attorney General, to conduct a study no later than January 1, 2023 and annually thereafter for the following 4 years on the effects of the provisions in the Act. • Requires GAO to submit to Congress a report on the impact of surprise billing provisions. • Requires GAO to submit to Congress a report on adequacy of provider networks.
Sec. 110. Consumer protections through application of health plan external review in cases of certain surprise medical bills.	• Allows for an external review to determine whether surprise billing protections are applicable when there is an adverse determination by a health plan beginning not later than January 1, 2022.
Sec. 111. Consumer protections through health plan requirement for fair and honest advance cost estimate.	• Requires health plans to provide an Advance Explanation of Benefits for scheduled services at least three days in advance to give patients transparency into which providers are expected to provide treatment, the expected cost, and the network status of the providers.
Sec. 112. Patient protections through transparency and patient-provider dispute resolution.	• Health care providers and facilities must verify, three days in advance of service and not later than one day after scheduling of service, what type of coverage the patient is enrolled in and provide notification of good faith estimate whether or not patient has coverage. • Requires the Secretary of HHS to establish a patient-provider dispute resolution process for uninsured individuals no later than January 1, 2022.
Sec. 113. Ensuring continuity of care.	• If a provider changes network status, patients with complex care needs have up to a 90-day period of continued coverage at in-network cost sharing rates to allow for a transition of care to an in-network provider.
Sec. 114. Maintenance of price comparison tool.	• Requires health plans to offer a price comparison tool for consumers.
Sec. 115. State All Payer Claims Databases.	• Establishes a grant program to create and improve State All Payer Claims Databases. • Requires recipients of the grants from this program to make data available to authorized users, including researchers, employers, health insurance issuers, third-party administrators, and health care providers for quality improvement and cost-containment purposes. The Secretary may waive these requirements if a State All Payer Claims Database is substantially in compliance.

	• Requires the Secretary of Labor to establish a standard national format that states may use in order to encourage self-insured plans to report to the state's database.
Sec. 116. Protecting patients and improving the accuracy of provider directory information.	• Requires health plans to have up-to-date directories of their in-network providers, which shall be available to patients online, or within one business day of an inquiry. • If a patient provides documentation that they received incorrect information from an insurer about a provider's network status prior to a visit, the patient will only be responsible for the in-network cost-sharing amount.
Sec.117.Timely bills for patients.	• Requires health care facilities and practitioners to give patients a list of services received upon discharge or end of a visit or by postal or electronic communication as soon as practicable and not later than 15 calendar days after discharge or date of visit. • The health care facility or practitioner shall submit to the health plan the bill not later than 30 calendar days after discharge or date of visit of the individual. A health plan, after receiving the bill from the health care facility or practitioner, shall complete adjudication of the bill not later than 30 calendar days after receiving the bill. The health care facility or practitioner shall send the adjudicated bill to the patient not later than 30 calendar days after receiving the adjudicated bill from the health plan. • If a patient receives a bill more than 90 calendar days after receiving care, the patient is not obligated to pay. • The timeline for submitting a bill may be extended if a patient or their provider is appealing an adverse coverage determination, or if an out-of-network provider is disputing a payment through open negotiation or Independent Dispute Resolution. • The Secretary of HHS shall promulgate regulations to account for any extenuating circumstances or types of billing (such as global packages for services provided during multiple visits) that may prevent a provider, facility, or health plan from complying with this provision. • Requires facilities and practitioners to give patients at least 45 days after the postmark date to pay bills.
Sec. 118. Advisory committee on ground ambulance and patient billing.	• Requires the Secretaries of Labor, HHS, and Treasury to establish an advisory committee for reviewing options to improve disclosure of charges and fees for ground ambulance services, inform consumers of insurance options for such services, and protect consumers from balance billing. • Requires a report on recommendations from the committee not later than 180 days after first meeting.

Sec. 201. Extension for community health centers, the national health service corps, and teaching health centers that operate GME programs.	• Extends mandatory funding for community health centers, the National Health Service Corps, and the Teaching Health Center Graduate Medical Education Program at current levels for each of fiscal years 2021 through 2024.
Sec. 202. Other programs.	• Extends mandatory funding for the Special Diabetes Program for Type I Diabetes and the Special Diabetes Program for Indians at current levels for each of fiscal years 2021 through 2024.