

PRESENTED AT

32nd Annual Health Law Conference

April 7-9, 2021

Live Webcast

Emerging Issues in Managed Care

Speakers:

Michael McMillan

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- Sec. 104. Health care provider requirements regarding surprise medical billing.
- Sec. 105. Ending surprise air ambulance bills.
- Sec. 106. Reporting requirements regarding air ambulance services.
- Sec. 107. Transparency regarding in-network and out-of-network deductibles and out-of-pocket limitations.
- Sec. 108. Implementing protections against provider discrimination.
- Sec. 109. Reports.
- Sec. 110. Consumer protections through application of health plan external review in cases of certain surprise medical bills.
- Sec. 111. Consumer protections through health plan requirement for fair and honest advance cost estimate.
- Sec. 112. Patient protections through transparency and patient-provider dispute resolution.
- Sec. 113. Ensuring continuity of care.
- Sec. 114. Maintenance of price comparison tool.
- Sec. 115. State All Payer Claims Databases.
- Sec. 116. Protecting patients and improving the accuracy of provider directory information.
- Sec. 117. Advisory committee on ground ambulance and patient billing.
- Sec. 118. Implementation funding.

TITLE II—TRANSPARENCY

- Sec. 201. Increasing transparency by removing gag clauses on price and quality information.
- Sec. 202. Disclosure of direct and indirect compensation for brokers and consultants to employer-sponsored health plans and enrollees in plans on the individual market.
- Sec. 203. Strengthening parity in mental health and substance use disorder benefits.
- Sec. 204. Reporting on pharmacy benefits and drug costs.

TITLE III—PUBLIC HEALTH PROVISIONS

Subtitle A—Extenders Provisions

- Sec. 301. Extension for community health centers, the National Health Service Corps, and teaching health centers that operate GME programs.
- Sec. 302. Diabetes programs.

Subtitle B—Strengthening Public Health

- Sec. 311. Improving awareness of disease prevention.
- Sec. 312. Guide on evidence-based strategies for public health department obesity prevention programs.
- Sec. 313. Expanding capacity for health outcomes.
- Sec. 314. Public health data system modernization.
- Sec. 315. Native American suicide prevention.
- Sec. 316. Reauthorization of the Young Women's Breast Health Education and Awareness Requires Learning Young Act of 2009.
- Sec. 317. Reauthorization of school-based health centers.

Subtitle C—FDA Amendments

- Sec. 321. Rare pediatric disease priority review voucher extension.
- Sec. 322. Conditions of use for biosimilar biological products.
- Sec. 323. Orphan drug clarification.
- Sec. 324. Modernizing the labeling of certain generic drugs.
- Sec. 325. Biological product patent transparency.

Subtitle D—Technical Corrections

- Sec. 331. Technical corrections.

TITLE I—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.

(a) PUBLIC HEALTH SERVICE ACT AMENDMENTS.—

(1) IN GENERAL.—Title XXVII of the Public Health Service Act (42 U.S.C. 300gg et seq.) is amended by adding at the end the following new part:

**“PART D—ADDITIONAL COVERAGE
PROVISIONS**

“SEC. 2799A-1. PREVENTING SURPRISE MEDICAL BILLS.

“(a) COVERAGE OF EMERGENCY SERVICES.—

“(1) IN GENERAL.—If a group health plan, or a health insurance issuer offering group or individual health insurance coverage, provides or covers any benefits with respect to services in an emergency department of a hospital or with respect to emergency services in an independent freestanding emergency department (as defined in paragraph (3)(D)), the plan or issuer shall cover emergency services (as defined in paragraph (3)(C))—

“(A) without the need for any prior authorization determination;

“(B) whether the health care provider furnishing such services is a participating provider or a participating emergency facility, as applicable, with respect to such services;

“(C) in a manner so that, if such services are provided to a participant, beneficiary, or enrollee by a nonparticipating provider or a nonparticipating emergency facility—

“(i) such services will be provided without imposing any requirement under the plan or coverage for prior authorization of services or any limitation on coverage that is more restrictive than the requirements or limitations that apply to emergency services received from participating providers and participating emergency facilities with respect to such plan or coverage, respectively;

“(ii) the cost-sharing requirement is not greater than the requirement that would apply if such services were provided by a participating provider or a participating emergency facility;

“(iii) such cost-sharing requirement is calculated as if the total amount that would have been charged for such services by such participating provider or participating emergency facility were equal to the recognized amount (as defined in paragraph (3)(H)) for such services, plan or coverage, and year;

“(iv) the group health plan or health insurance issuer, respectively—

“(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment; and

“(II) pays a total plan or coverage payment directly to such provider or facility, respectively (in accordance, if applicable, with the timing requirement described in subsection (c)(6)) that is, with application of any initial payment under subclause (I), equal to the amount by which the out-of-network rate (as defined in paragraph

(3)(K) for such services exceeds the cost-sharing amount for such services (as determined in accordance with clauses (ii) and (iii)) and year; and

“(v) any cost-sharing payments made by the participant, beneficiary, or enrollee with respect to such emergency services so furnished shall be counted toward any in-network deductible or out-of-pocket maximums applied under the plan or coverage, respectively (and such in-network deductible and out-of-pocket maximums shall be applied) in the same manner as if such cost-sharing payments were made with respect to emergency services furnished by a participating provider or a participating emergency facility; and

“(D) without regard to any other term or condition of such coverage (other than exclusion or coordination of benefits, or an affiliation or waiting period, permitted under section 2704 of this Act, including as incorporated pursuant to section 715 of the Employee Retirement Income Security Act of 1974 and section 9815 of the Internal Revenue Code of 1986, and other than applicable cost-sharing).

“(2) AUDIT PROCESS AND REGULATIONS FOR QUALIFYING PAYMENT AMOUNTS.—

“(A) AUDIT PROCESS.—

“(i) IN GENERAL.—Not later than October 1, 2021, the Secretary, in consultation with the Secretary of Labor and the Secretary of the Treasury, shall establish through rulemaking a process, in accordance with clause (ii), under which group health plans and health insurance issuers offering group or individual health insurance coverage are audited by the Secretary or applicable State authority to ensure that—

“(I) such plans and coverage are in compliance with the requirement of applying a qualifying payment amount under this section; and

“(II) such qualifying payment amount so applied satisfies the definition under paragraph (3)(E) with respect to the year involved, including with respect to a group health plan or health insurance issuer described in clause (ii) of such paragraph (3)(E).

“(ii) AUDIT SAMPLES.—Under the process established pursuant to clause (i), the Secretary—

“(I) shall conduct audits described in such clause, with respect to a year (beginning with 2022), of a sample with respect to such year of claims data from not more than 25 group health plans and health insurance issuers offering group or individual health insurance coverage; and

“(II) may audit any group health plan or health insurance issuer offering group or individual health insurance coverage if the Secretary has received any complaint or other information about such plan or coverage, respectively, that involves the compliance of the plan or coverage, respectively, with either of the requirements described in subclauses (I) and (II) of such clause.

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First appeared as part of the conference materials for the
32nd Annual Health Law Conference session

"Emerging Issues in Managed Care"