Consolidated Appropriations Act, 2021 (H.R. 133)
External Surprise Billing FAQs

Statute Overview

The Consolidated Appropriations Act, 2021 was enacted by Congress and signed by President Trump on December 27, 2020. This federal law contains several price transparency requirements as well as protections for consumers from being balance billed by providers.

- The **No Surprises Act (NSA)** sets forth requirements regarding the cost sharing for emergency services and certain post-stabilization and other services, as well as a scheme for providers and payers to settle payment disputes through independent dispute resolution ("baseball" arbitration). It also introduces new requirements for provider directories, plan ID cards, and continuity of care.
- The legislation also introduces new **transparency** requirements related to broker and consultant compensation disclosures, mental health parity, and a prohibition on "gag clauses" in provider contracts.
- **No surprise (balance) billing** (enforcement date: January 1, 2022): Requires that emergency services – regardless of where they are provided – be treated as in-network services without the need for prior authorization. Also bans billing for out-of-network charges for certain "ancillary" services by out-of-network providers at in-network facilities (e.g., anesthesiologist or assistant surgeon).
    - An independent dispute resolution (IDR) process (facilitated by the Department of Health and Human Services (HHS)) will be introduced as part of this requirement for instances when out-of-network providers and plans cannot reach agreement on payment.

General FAQs (Fully Insured)

How will Kaiser Permanente comply with the No Surprises Act and what changes will be needed?

Kaiser Permanente is actively implementing the requirements of the Consolidated Appropriations Act, 2021 as well as the Transparency in Coverage regulation. This is an evolving process as federal regulators continue to issue regulations, sub-regulations, guidance, and other interpretive and technical advice that involve implementation issues.

Kaiser's implementation effort will address issues applicable to self-funded and fully insured group and individual plan designs issued or administered by Kaiser, Kaiser Permanente Insurance Company, and Kaiser Permanente Foundation Health Plan of Washington Options, Inc. As part of the implementation process, we seek to understand the ever evolving federal and state law requirements regarding the payment of claims for non-participating providers' provision of covered services and implementing changes necessary for the NSA. To this end, existing policies and procedures will be modified and new ones adopted to further document implementation decisions.

What providers and facilities does the No Surprises Act apply to?

The No Surprises Act applies to three types of health care providers and facilities:

- Covered emergency items and services performed by an out-of-network facility or provider
- Covered non-emergency medical items and services performed by an out-of-network provider at an in-network facility
- Out-of-network air ambulance items and services

What is Kaiser Permanente's approach for members who are in need of emergency care and are only able to receive care at a non-participating emergency facility?

Although few changes are required, Kaiser Permanente is implementing the requirements as outlined in the No Surprises Act and interim final rules when members need care from an out-of-network provider for emergency services and air ambulance services. When a member must receive emergency care from out-of-network providers, Kaiser will calculate the member cost-sharing based on the recognized amount, which is based on the All-Payer Model Agreement, the specified state law, or the qualifying payment amount (QPA) for emergency services or the lesser of the QPA or billed charges for air ambulance services. Upon receiving a claim, Kaiser will pay the provider an out-of-network rate less the member cost-sharing.

Did Kaiser make any changes to the Summary of Benefits and Coverage (SBC) to reflect compliance with the No Surprises Act (CAA)?

Kaiser is continuing to evaluate the impact of the No Surprises Act requirements on various provisions of Kaiser's coverage documents including but not limited to the Summary of Benefits Coverage, Evidence of Coverage, and Explanation of Benefits.

For fully insured plans, can you confirm evidence of coverages (EOCs) will be updated to describe these requirements?

EOC changes will reflect the requirements and business decisions made during the implementation process.

Independent Dispute Resolution

Who can request an independent dispute resolution (IDR)?

Either an insurer/health plan or a provider may request an independent dispute resolution when the federal law applies. There is a 30-day negotiation period to resolve disputes related to reimbursement for out-of-network covered items and services. The negotiation period begins after the provider receives payment or a claim denial. Four days after the end of the 30-day negotiation period when the parties have not agreed to the amount owed, either the insurer/health plan or the provider can request an IDR.

Model Notices

Where will the surprise billing model notice be posted?

The model notices for all regions except KPWA will be posted on the "Important Notices" section on kp.org and the "Pay Bills FAQ" section.

The model notices for KPWA will be posted to kp.org/wa, specifically in the Forms and Publication – Kaiser Permanente Section:

- https://healthy.kaiserpermanente.org/washington/support/forms#billingforms.

Balance Billing

Will the No Surprises Act apply if a member chooses to see an out-of-network (OON) provider?

No. The No Surprises Act does not affect claims for members who choose to use OON providers. Balance billing may continue for those claims.

Does Kaiser abide by any state balance billing laws when determining claims?

Yes, Kaiser Permanente abides by applicable state balance billing laws when they apply to item or service, the provider rendering such item or service and to the plan and KP.

Qualified Payment Amounts

How is Kaiser Permanente calculating qualified payment amounts (QPAs)?

A member's cost sharing will be calculated according to the hierarchy (All-Payer Model Agreement, specified state law or the qualifying payment amount) set forth in the statute and implementing regulations. A member will not be required to pay more cost sharing than the recognized amount. Currently, Kaiser Permanente is working to calculate QPAs with the assistance of a third-party vendor and has secured a database when it does not have sufficient data to calculate the QPA based on median contract rates in accordance with the regulations.

Cost Impacts

What cost impacts (increase or decrease) will there be for employer group plans?

Kaiser Permanente will not charge additional fees for services related to implementing and complying with federal regulations.

General FAQs (Self-Funded)

What plan changes will Kaiser Permanente make on behalf of self-funded plans administered for employer groups because of these requirements?

Kaiser Permanente will apply federal law when the No Surprises Act applies; otherwise, there will be no change in the way we administer self-funded plans.

How will Kaiser Permanente comply with the federal requirements and what specific changes will be needed?

Kaiser Permanente is actively implementing the requirements of the Consolidated Appropriations Act, 2021 as well as the Transparency in Coverage regulation. This is an evolving process as federal regulators continue to issue regulations, sub-regulations, guidance, and other interpretive and technical advice that involve implementation issues.

Kaiser's implementation effort will be compliant with the No Surprises Act and address issues applicable to self-funded and fully insured group and individual plan designs issued or administered by Kaiser, Kaiser Permanente Insurance Company, Kaiser Permanente Foundation Health Plan of Washington, and Kaiser Permanente Foundation Health Plan of Washington Options, Inc. As part of the implementation

process, we are understanding federal and state law requirements regarding the payment of claims for non-participating providers' provision of covered services and implementing changes necessary for implementation of the NSA. To this end, existing policies and procedures will be modified and new ones adopted to further document implementation decisions.

Out-of-Network Services

What is Kaiser Permanente's approach for members who have an emergency and cannot avoid receiving care at a non-participating emergency facility ("no-choice out of network claims")? For example, if a member is outside of our service area and needs to be air lifted to the nearest hospital, how will Kaiser Permanente manage that situation?

Kaiser Permanente is implementing the requirements as outlined in the No Surprises Act and interim final rules when members need care from an out-of-network provider for emergency services and air ambulance services. When a member must receive care from out-of-network providers, Kaiser will calculate the member cost-sharing based on the recognized amount, which is based on the All-Payer Model Agreement, the specified state law, or the QPA for emergency services or the lesser of the QPA or billed charges for air ambulance services. Upon receiving a claim, Kaiser will pay the provider an out-of-network rate less the member cost-sharing.

Is Kaiser Permanente leveraging a third party reviewer for "no choice out of network claims?" If so, will this relationship continue or is Kaiser taking a different approach?

Kaiser Permanente currently (prior to the No Surprises Act effective date) has internal processes in place, as well as contracts with vendors, to review out-of-network claims, negotiate, and make payments. We are updating our processes and evaluating options to incorporate the requirements of the No Surprises Act.

How will Kaiser Permanente comply with the requirement for non-emergency services at an in-network facility provided by an out-of-network provider?

Kaiser Permanente is actively working to implement the regulations and requirements that relate to surprise billing protections for certain non-emergency services provided by an out-of-network provider at an in-network facility.

Cost Impacts

What cost impacts (increase or decrease) will there be for employer group plans?

Kaiser Permanente will not charge additional fees for services related to implementing the No Surprises Act.

Surprises Act and Washington's Balance Billing Protection Act

What is Kaiser Permanente's approach for the federal surprise bill law? Will Kaiser provide the option for self-insured plans to follow both federal and state law assuming a state's surprise bill law is more generous, and the state will still allow self-insured plans to opt in?

For KP jurisdictions, state laws in Georgia, Virginia, and Washington permit self-funded groups to "opt-in." This applies only to Kaiser Permanente Insurance Company (KPIC) (ASO entity for Kaiser self-funded groups), Kaiser Foundation Health Plan Washington (KFHPWA), and Kaiser Foundation Health Plan of

Washington Options, Inc. (KFHPWAO). Should a plan decide to “opt-in”, state law will apply when it applies to the plan, the healthcare provider, and the item or service as described in the preamble to the July IFR. For example, certain post-stabilization services will be treated as emergency services when the self-funded member cannot be repatriated to an in-network facility and/or the member does not consent to treatment by OON providers.