CONSOLIDATED APPROPRIATIONS ACT, 2021 (CAA)

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avis budget group

The Consolidated Appropriations Act, 2021 (CAA) established protections for consumers related to surprise billing and transparency in health care.

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YOUR RIGHTS AND PROTECTIONS AGAINST SURPRISE MEDICAL BILLS

When you get emergency care or you're treated by an out-of-network provider at an in-network hospital, or ambulatory surgical center or by an air ambulance provider, you are protected from surprise billing or balance billing.

WHAT IS "BALANCE BILLING" (SOMETIMES CALLED "SURPRISE BILLING")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, like a copayment, coinsurance, or deductible. You may have additional costs or must pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

- "Out-of-network" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays, and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your plan's deductible or annual out-of-pocket limit.

- "Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

YOU'RE PROTECTED FROM BALANCE BILLING FOR:

Emergency services

If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). You can't be balance billed for these emergency services. This includes services you may get after you're in stable condition unless you give written consent and give up your protections not to be balance billed for these post-stabilization services.

When you receive medically necessary air ambulance services from an out-of-network provider, your cost share will be the same amount that you would pay if the service was provided by an in-network provider. Any coinsurance or deductible will be based on rates that would apply if the services were supplied by an in-network provider.

Certain services at an in-network hospital or ambulatory surgical center

When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers can bill you is your plans' in-network costs-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers can't balance bill you and may not ask you to give up your protections not to be balance billed.

If you get other types of services at these in-network facilities, out-of-network providers can't balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protection from balance billing. You also aren't required to get out-of-network care. You can choose a provider or facility in your plans' network.

WHEN BALANCE BILLING ISN'T ALLOWED, YOU ALSO HAVE THESE PROTECTIONS:

You're only responsible for paying your share of the cost (like the copayments, coinsurance, and deductible that you would pay if the provider or facility was in-network). Your health plan will pay any additional costs to out-of-network providers and facilities directly.

- Generally, your health plan must:
  - Cover emergency services without requiring you to get approval for services in advance (also known as "prior authorization").
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your in-network deductible and out-of-pocket limit.

If you believe you've been wrongly billed, you may contact the No Surprises Help Desk at 800-985-3059.

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

TRANSPARENCY IN HEALTH CARE

The RxDC is the data collection required under section 204 of Title II (Transparency) of Division BB of the CAA. The law requires insurance companies and employer-based health plans to submit information about prescription drug and health care spending to the Departments of Health & Human Services, Labor, and the Treasury.

The Transparency in Coverage rules also require insurance carriers and plan sponsors to post information about the cost to plan members for in-network and out-of-network healthcare services through machine-readable files (MRF) on a public employer site.

Below are the links to the machine-readable files on our insurance carrier sites.

Aetna

https://Health1.Aetna.com/app/public/#/one/insurerCode=AETNACVS_I&brandCode=ALICSI/machine-readable-transparency-in-coverage?searchTerm=15421406&lock=true

Surest

Transparency in Coverage (uhc.com)

Kaiser Permanente (CA)

Transparency In Pricing Machine-Readable Files | Kaiser Permanente

Kaiser Permanente (HI)

www.kp.org

HMSA

https://hmsa.com/employers/service-center/administrators/transparency-in-coverage-rule-and-consolidated-appropriations-act/

Triple-S Salud

Machine Readable Files - Triple-S Salud (grupotriples.com)