Understanding the No Surprises Act

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Daphne L. Kackloudis, Esq.
Ashley B. Watson, Esq.

Introduction

- Who are we?
- What is BMD?

AGENDA

- Introductions
- No Surprises Act – What is it?
- What led to the No Surprises Act?
- The Nuts and Bolts of the Law and Rules
- Questions

No Surprises Act – What is it?

Overview

- The No Surprises Act is a federal consumer protection law that helps control the practice known as “surprise billing” for medical care.
- The Act was signed into law on **December 27, 2020**, as part of the Consolidated Appropriations Act of 2021.
- Most sections of the legislation became effective on Jan. 1, 2022.

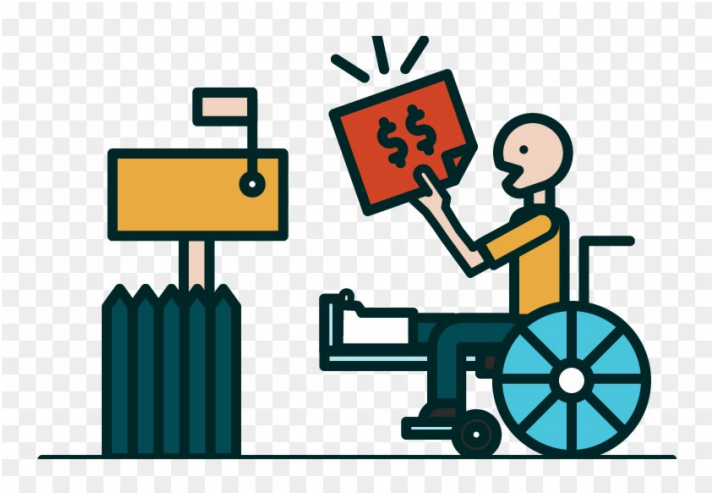
Overview

- Three rules are primarily being used to implement the No Surprises Act.
  - Part I – Establishes new protections from surprise billing and excessive cost-sharing for consumers for emergency services and certain non-emergency inpatient services.
  - Air Ambulance Rule – Requires collection of data on the air ambulance provider industry.
  - Part II
    - Requires health care providers and facilities to provide a good faith estimate of charges to uninsured or self-pay individuals.
    - Details the federal arbitration process/independent dispute resolution process that providers, facilities or providers of air ambulance services, and health plans or issuers will use to determine final payment beyond allowable patient cost-sharing for certain out-of-network healthcare services in situations where the No Surprises Act prohibits surprise billing.

What led to the No Surprises Act?

Surprise Billing – The Practice

- When a person with health insurance coverage gets care from an out-of-network (OON) provider, their health plan usually does not cover the entire OON cost, leaving the person with higher costs than if they had been seen by an in-network provider.
- In many cases, the OON provider may bill the individual for the difference between the billed charge and the amount paid by their plan or insurance, unless prohibited by state law.
- A “balance bill” may come as a surprise for many people. This can happen when a person with health insurance unknowingly gets medical care from a provider or facility outside their health plan’s network.
- Surprise billing happens in both emergency and non-emergency care.



The Impact on Consumers

- Payments made to providers by people who got a surprise bill for emergency care were more than 10 X higher than those made by other individuals for the same care.
- OON cost sharing and surprise bills usually do not count toward a person's deductible and maximum out-of-pocket limit.
  - Individuals with surprise bills may have to spend more out-of-pocket because they have to pay their OON cost sharing and surprise billing amounts even if they have already met their deductible and maximum out-of-pocket limits.
- Nine percent of individuals who got surprise bills paid more than $400 to providers, which may result in financial distress for consumers.
  - Recent findings that show 40% of Americans struggle to find $400 to pay for an unexpected bill.
- Studies have shown that between 2010-2016, more than 39% of emergency department visits to in-network hospitals resulted in an OON bill, increasing to 42.8% in 2016.
  - During the same period, the average amount of a surprise medical bill also increased from $220 to $628.

Source: https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period

The Nuts and Bolts of the Act and the Rules

Part I Interim Final Rule

- The Part I regulation protects people from surprise medical bills for emergency services, air ambulance services provided by OON providers, and non-emergency services provided by OON providers at in-network facilities.
- Under the rule, if a plan or health insurance issuer provides or covers any benefits for emergency services, this rule requires emergency services to be covered:
  - Without any prior authorization.
  - Regardless of whether the provider is an in-network provider or an in-network emergency facility.
  - Regardless of any other term or condition of the plan or coverage other than the exclusion or coordination of benefits, or a permitted affiliation or waiting period.
- **PLEASE NOTE: THIS PART OF THE RULE APPLIES ONLY TO SURPRISE MEDICAL BILLS FOR EMERGENCY SERVICES PROVIDED IN AN ED AND NON-EMERGENCY SERVICES PROVIDED BY OUT-OF-NETWORK PROVIDERS AT IN-NETWORK HOSPITALS, OUTPATIENT HOSPITAL DEPARTMENTS, CRITICAL ACCESS HOSPITALS, AND AMBULATORY SURGICAL CENTERS.**

Part I Interim Final Rule – Cost Sharing

- The rule:
  - Limits cost sharing for OON services subject to these protections to no higher than in-network levels;
  - Requires such cost sharing to count toward any in-network deductibles and out-of-pocket maximums; and
  - Prohibits balance billing.
- Note: The ban on balance billing for non-emergency services only applies to plan covered services. If a non-emergency service is not covered under the in-network benefits and terms of coverage under an individual's health plan, then the rules on balance billing do not apply for these services.

Part I Interim Final Rule – Cost Sharing

- Consumer cost-sharing amounts for emergency services covered by the rule must be calculated based on one of the following amounts:
  1. An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
  2. An amount determined under a specified state law (if there is no such applicable All-Payer Model Agreement).
  3. If neither of the above apply, the lesser amount of either the billed charge or the qualifying payment amount (QPA), which is generally the plan's or issuer's median contracted rate.

Part I Interim Final Rule – OON Rates

- Under the rule, the total amount to be paid to the provider or facility, including any cost sharing, is based on:
  - An amount determined by an applicable All-Payer Model Agreement under section 1115A of the Social Security Act.
  - If there is no such applicable All-Payer Model Agreement, an amount determined by a specified state law.
  - If there is no such applicable All-Payer Model Agreement or specified state law, an amount agreed upon by the plan or issuer and the provider or facility.
  - If none of the three conditions above apply, an amount determined by an independent dispute resolution (IDR) entity.
    - *See Part II Interim Final Rule*

Part I Interim Final Rule – Notice to Consumers

- Under the rule, certain health care providers and facilities must make publicly available, post on a public website, *and* provide to individuals a one-page notice about:
  - NSA requirements and those included in the implementing regulations.
  - Any applicable state balance billing limitations or prohibitions.
  - How to contact appropriate state and federal agencies if someone believes the provider or facility has violated the requirements described in the notice.
- This requirement applies to OON emergency facilities and OON providers and facilities furnishing non-emergency services (other than ancillary services) at in-network facilities.

Notice and Consent Exception

- The NSA requires that an OON provider notify a patient of its OON status and obtain the patient's written consent to receive OON services more than 72 hours before the service is delivered. Or, if the appointment is scheduled within 72 hours of the service, notice and consent documents must be given on the day the appointment is made, at least 3 hours before the service is performed.
- There is no notice and consent exception allowed for services where patients are typically unable to select their specific provider.
  - This "no exception group" is defined as any service relating to emergency medicine, anesthesiology, pathology, radiology, neonatology, diagnostic testing, and those provided by assistant surgeons, hospitalists, and intensivists.
  - Also applies when there are no in-network provider options.
  - The Secretary of HHS has the option to add to this list over time and to remove certain advanced diagnostic laboratory tests.

Part II Interim Final Rule

- This rule:
  - Requires good faith estimates for uninsured (or self-pay) individuals.
  - Establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services.
  - Implements provisions related to the independent dispute resolution process between providers and health plans.
  - Requires a patient-provider dispute resolution process.
  - Provides for expanded rights to external review.
- **PLEASE NOTE: THIS RULE HAS MUCH WIDER APPLICABILITY THAN PART I. IT APPLIES TO THE VAST MAJORITY OF HEALTH CARE PROVIDERS, EVEN IF PART I DOES NOT.**
- MGMA sent a letter to HHS on January 26, 2022, asking HHS and CMS to delay enforcement of the GFE requirement to allow practices to better prepare.

Part II Interim Final Rule – Independent Dispute Resolution

- This rule establishes the federal independent dispute resolution (IDR) process that OON providers, facilities, providers of air ambulance services, plans, and issuers in the group and individual markets may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation.
- Not all items and services are eligible for the federal IDR process.
  - This process applies only to those services for which balance billing was prohibited under the Part I rule.

Part II Interim Final Rule – Independent Dispute Resolution

- Before initiating the federal IDR process, disputing parties must initiate a 30-day "open negotiation" period to determine a payment rate.
- If the open negotiation fails, either party may initiate the IDR process by sending a standard notice to the other party and the Secretary of the HHS.
- Independent Dispute Resolution Process:
  - The parties may jointly select a certified IDR entity to resolve the dispute.
    - The certified IDR entity and personnel of the entity assigned to the case must attest that they have no conflicts of interest with either party.
    - If the parties cannot jointly select a certified IDR entity or if the selected certified IDR entity has a conflict of interest, the Departments will select a certified IDR entity.

Part II Interim Final Rule – Independent Dispute Resolution

- After selecting a certified IDR entity, the parties each submit their offers for payment along with supporting documentation.
- The certified IDR entity will then issue a binding determination selecting one of the parties' offers as the OON payment amount.
- Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process ($200-500).

Part II Interim Final Rule – Independent Dispute Resolution

- When making a payment determination, certified IDR entities must begin with the presumption that the qualifying payment amount (QPA) is the appropriate OON amount.
  - Remember that the QPA is generally the median of contracted rates for a specific service in the same geographic region within the same insurance market as of January 31, 2019.
- For the IDR entity to deviate from the offer closest to the QPA, any information submitted must clearly demonstrate that the value of the item or service is materially different from the QPA.
- In that case, arbitrators must also consider demonstrations of good faith to reach agreement and any contracted rates between the two parties during the previous four years; market shares of both parties; patient acuity; and the level of training, experience, and quality of the provider.
- The arbitrator is prohibited from considering the provider's billed charges; usual, customary, and reasonable rate benchmarks; and Medicare or Medicaid rates.

Independent Dispute Resolution Action	Timeline (business days)
30-business-day open negotiation period	30 days – starts on day of initial payment or notice of denial of payment
If negotiation fails, initiate IDR process	4 days – starts the business day after the open negotiation period ends
Mutual agreement on certified IDR entity selection	3 days – starts on IDR initiation date
Department selects certified IDR entity if parties cannot choose	6 days – starts on IDR initiation date
Submit payment offers and additional information to certified IDR entity	10 days – from the date of certified IDR entity selection
Payment determination made	30 days – from the date of certified IDR entity selection
Payment submitted to applicable party	30 days – after the payment determination

Part II Interim Final Rule – Good Faith Estimates

- When scheduling a service, providers are required to inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking.
- Under the rule, the provider must provide a good faith estimate of expected charges for items and services to an uninsured (or self-pay) individual, meaning an individual that:
  - Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program, or a health benefits plan health benefits plan under chapter 89 of title 5, United States Code; or
  - Has benefits for such items/services but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

Part II Interim Final Rule – Good Faith Estimates

- **The availability of a good faith estimate must be offered upon scheduling or upon request to applicable patients.**
- The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities.
  - Ex: For a cochlear implant surgery, the good faith estimate might include the cost of the surgery, any labs or tests, and the anesthesia that might be used during the surgery.
    - If an item or service is something that is *not* scheduled separately from the surgery itself, it will generally be included in the good faith estimate. This might include diagnostics done the same day as the surgery or anesthesia during the surgery.
    - Other items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or therapy in the weeks after the surgery, won't be included in the good faith estimate.

Part II Interim Final Rule – Good Faith Estimates

- Good faith estimates must also include:
  - Patient name and date of birth.
  - Description/date of the primary item or service in clear, understandable language.
  - Itemized list of items or services, grouped by each provider/facility, reasonably expected to be furnished for the primary item or service and items or services reasonably expected to be furnished in conjunction with the primary item or service for that period of care, including those provided by the convening provider/facility and any co-providers / co-facilities.
  - Applicable diagnosis codes, expected service codes, and expected charges associated with each listed item or service.
  - Name, NPI, and TIN of each provider/facility represented in the good faith estimate and the states and office or facility locations where the items or services are expected to be furnished.
  - List of items or services that the convening provider/facility anticipates will require separate scheduling and that are expected to occur before or after the expected period of care for the primary item or service.
  - Appropriate disclaimers.

Time Frame for Good Faith Estimates	
Item/service scheduled at least:	Good Faith Estimate to be provided not later than:
10 days in advance	3 business days after scheduling
3 days in advance	1 business day after scheduling
Individual Requested	3 business days after request

Q&A

How can you supply diagnosis and procedure codes prior to services?

The good faith estimate to be provided to the patient must include expected charges for the items or services that are reasonably expected to be provided. Based on the type of service you anticipate providing to the patient (e.g., primary care visit for established patient), you'll have to estimate the diagnosis and procedure codes you're likely to use and the associated costs. The GFE should be updated if you obtain additional information prior to the delivery of the service. The NSA requires providers to act in good faith when estimating costs for services; even if the cost of the items or services ends up being more than $400 greater than your estimate, if you can demonstrate that you acted in good faith when developing the estimate, you should not be subject to liability.

I heard it was also to cover High Deductible patients?

Right now, the good faith estimate requirement applies only to uninsured and self-pay patients. If your patient does not want to use their insurance and you allow them to present as self-pay, then they will fall into the category of patients for whom you'll need to provide a good faith estimate.

Q&A

To what types of health care providers does the GFE requirement apply?
"Health care provider" means a physician or other health care provider who is acting within the scope pf practice of that provider's license or certification under applicable State law.

To what types of services does the GFE requirement apply?
"Items or services" includes "all encounters, procedures, medical tests, supplies, prescription drugs, durable medical equipment, and fees (including facility fees) provided or assessed in connection with the provision of health care. The definition…encompasses and accurately defines the types of items or services that are expected to be reported in the good faith estimate including items or services such as those related to dental health, vision, substance use disorders and mental health."

What kinds of forms, policies, etc. do we need to have to comply with the GFE requirements?
It is a best practice to have a GFE policy to implement the GFE requirements of the NSA. You are also required to develop a GFE form and notice.

Q&A

Do providers need to factor in financial assistance an uninsured or self-pay individual may receive when calculating the expected charges for items or services included in the GFE?

Yes. The GFE must reflect the expected charges, including any expected discounts or other relevant adjustments that the provider or facility expects to apply to an uninsured or self-pay individual's actual billed charges.

Does the GFE requirement apply to sliding-fee scale patients?

Yes, if a sliding-fee scale patient is uninsured or self-pay then you are required to give them a GFE. While the patient may end up paying less than expected charges, they still have the right to know how much the charge could be. When presenting the GFE, you can take that opportunity to also explain the sliding scale and how much the actual cost of healthcare services will be.

Q&A

Do providers need to provide a GFE to uninsured or self-pay individuals who have zero financial responsibility?

Yes. All uninsured or self-pay individuals who schedule items or services or request an estimate must be provided a GFE. A GFE is required even if the uninsured or self-pay individual has no estimated financial responsibility because the actual billed charges for the items or services are not guaranteed to be $0 and a GFE is required to initiate the patient provider dispute resolution process if actual billed charges are at least $400 greater than the estimate.

Do I need to keep a copy of the GFE?

Yes. A GFE issued to an uninsured or self-pay individual is considered part of the patient's medical record and must be maintained in the same manner as a patient's medical record. Convening providers and convening facilities must provide a copy of any previously issued good faith estimate furnished within the last 6 years to an uninsured or self-pay individual upon the request of the individual.

Q&A

Are we allowed to make a blanket GFE?

No. You'll need to make a good faith estimate for each patient based on their specific circumstance, the services they are to receive, their acuity, etc. *EXCEPTION: see next FAQ.*

What if my patient has recurring services?

Per CMS, a convening provider or convening facility may issue a single GFE for recurring primary items or services if both of the following requirements are met:

- The GFE for recurring items or services includes, in a clear and understandable manner, the **expected scope of the recurring primary items or services** (such as timeframes, frequency, and total number of recurring items or services);
- The scope of a GFE for recurring primary items or services **does not exceed 12 months**.

Part II Interim Final Rule – Patient-Provider Dispute Resolution

- The rule also provides for a patient-provider dispute resolution process to determine a payment amount in a situation where an uninsured or self-pay individual receives a good faith estimate and then is billed for an amount substantially in excess of the good faith estimate.
- A patient's bill will be determined eligible for the patient-provider dispute resolution process if:
  - The patient received a good faith estimate,
  - The process is initiated within 120 calendar days of the patient receiving the bill, and
  - The bill is substantially in excess of the good faith estimate.
- HHS defines "substantially in excess" as the billed charges being at least $400 more than the good faith estimate for any provider or facility listed on the good faith estimate.

Part II Interim Final Rule – Patient-Provider Dispute Resolution

- Administrative fee of $25 (adjusted annually)
- If eligible, HHS will submit the dispute to selected dispute resolution entities (SDRs)
- The rule establishes timelines for the patient-provider dispute resolution process:
  - SDR notifies provider/facility of claim and validates the initiation notice
  - Provider has 10 days to respond with credible evidence to support higher billed charges
  - SDR makes decision within 30 days following receipt of information from provider
    - Provider will be bound to their good faith estimate if no credible evidence is presented
    - If credible evidence is presented, the charge will be determined as the lesser of (i) billed charges or (ii) median payment amount paid by plan/issuer for same or similar service, by same or similar provider in geographic area reflected in independent database
    - For unjustified new items (not on good faith estimate) the payment amount will be $0

Part II Interim Final Rule – External Review

- The rule expands the scope of adverse benefit determinations eligible for external review to include determinations that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations.
- In addition, under these interim final rules, grandfathered plans that are not otherwise subject to external review requirements will be subject to external review requirements for coverage decisions that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act.

Interplay Between Federal and State Laws

- Many states have existing laws regulating surprise billing.
- For the most part, the new federal law will simply supersede state laws.
  - Notably, because ERISA generally prohibits states from regulating self-insured group health plans, existing state laws only protect people enrolled in fully-insured health plans, whereas the new federal law will encompass self-insured plans too.
- State laws will continue to matter in two cases.
  - First, when state laws place requirements on providers or insurers that go beyond the new federal law, those requirements will remain in place.
  - Second, the new federal law specifies that the amount fully-insured plans must pay providers for surprise OON services will continue to be governed by state law in states that have a surprise billing law, rather than by the arbitration procedure under the new federal law.

Other State Laws

State	State Surprise Billing Law	Statement about the NSA?
AZ	Arizona Senate Bill 1441	SB 1441 works in tandem with NSA.
CA	California Assembly Bill 72; Senate Bill 510 (applies to surprise billing related to COVID-19 testing)	AB 72 and SB 510 work in tandem with NSA.
CO	Colorado House Bill 19-1174	HB 19-1174 works in tandem with NSA.
FL	Florida House Bill 221	HB 221 works in tandem with NSA.
IL	Public Act 096-1523	NSA's ban on balance billing is more comprehensive than Illinois' law, but they work in tandem.
IN	Indiana House Bill 1004	HB 1004 works in tandem with NSA.
MD	Health General Section 19-710(o)	Section 19-710(o) works in tandem with NSA.
NV	Nevada Assembly Bill 469	AB 469 works in tandem with NSA.
TX	Texas Senate Bill 1264	Texas Medical Association sued HHS over the No Surprises Act and is awaiting an outcome.
WA	Washington House Bill 1065	HB 1065 works in tandem with NSA.

*KS, KY, NC, OK, PA, and WI currently do not have surprise billing laws in statute

BMD
Brennan Manna Diamond

LISTEN. SOLVE. EMPOWER.

Questions?

Daphne Kackloudis, Esq.
(614) 246-7508
dlkackloudis@bmdllc.com

Ashley Watson, Esq.
(614) 246-7518
abwatson@bmdllc.com