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No Surprises Act – Surprise Balance Billing

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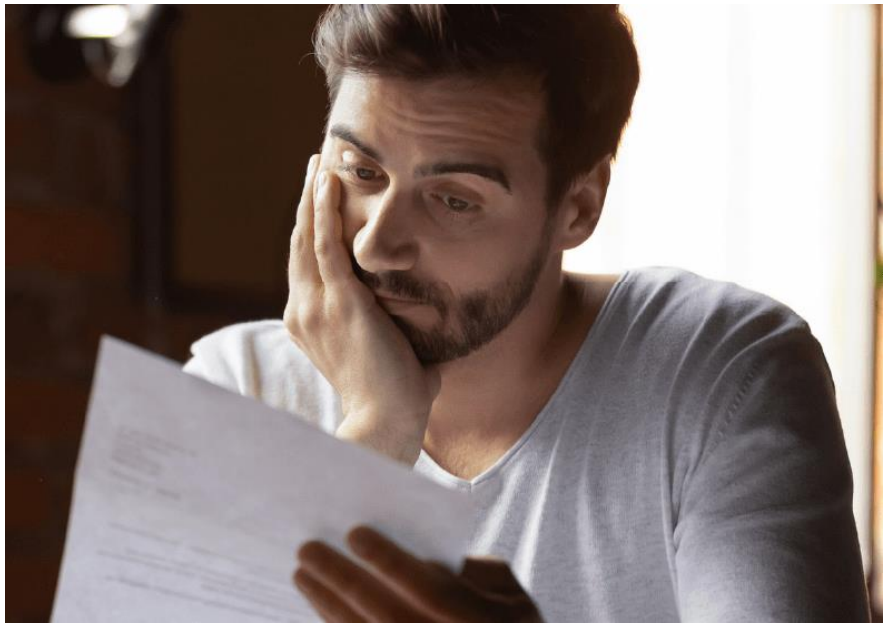
No Surprises Act

HHS, the DOL and Treasury, along with the Office of Personnel Management (OPM), released Interim Final Rules (IFR) under the **No Surprises Act**.

Requirements Related to Surprise Billing, Part I was released on July 1, 2021 and focused on determining the qualified payment amount, post-stabilization care procedures, and defining emergency care under the Act.

Requirements Related to Surprise Billing, Part II, which was issued on September 30, 2021 outlined the federal independent dispute resolution (IDR) process (arbitration), good-faith estimate requirements for uninsured or self-pay individuals, patient-provider dispute resolution processes for uninsured or self-pay individuals, and external review provisions of the No Surprises Act.

What Does the Act Do?



- Holds patients harmless from surprise medical bills, including from air ambulance providers, by ensuring they are only responsible for their in-network cost-sharing amounts, including deductibles, in both emergency situations and *certain* non-emergency situations where patients do not have the ability to choose an in-network provider.
- 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.
- Creates a framework that takes patients out of the middle and allows health care providers and insurers to resolve payment disputes without involving the patient.
- Insurers will make a payment to the provider that is determined either through negotiation between the parties or an independent dispute resolution (IDR) process. There is no minimum payment threshold to enter IDR, and claims may be batched together to ease administrative burdens.

What Does the Act Do?

- Provides additional consumer protections when insurance companies change networks, including a transition of care for people with complex care needs and appeal rights for consumers.
- Empowers consumers by providing a true and honest cost estimate that describes which providers will deliver their treatment, the cost of services, and provider network status.
- Requires health plan cover emergency services without requiring prior authorization.
- Requires health plans to provide an explanation of benefits showing that participant cost-sharing for protected services was based on in-network rates.
- Requires health plans to count any amounts participants pay towards protected services provided out-of-network towards their in-network deductibles and out-of-pocket limits.
- Requires health plans to make a notice explaining the surprise billing rules publicly available. The regulations include a template for this notice, which must be posted on the plan's public website and be included along with each explanation of benefits for protected services.

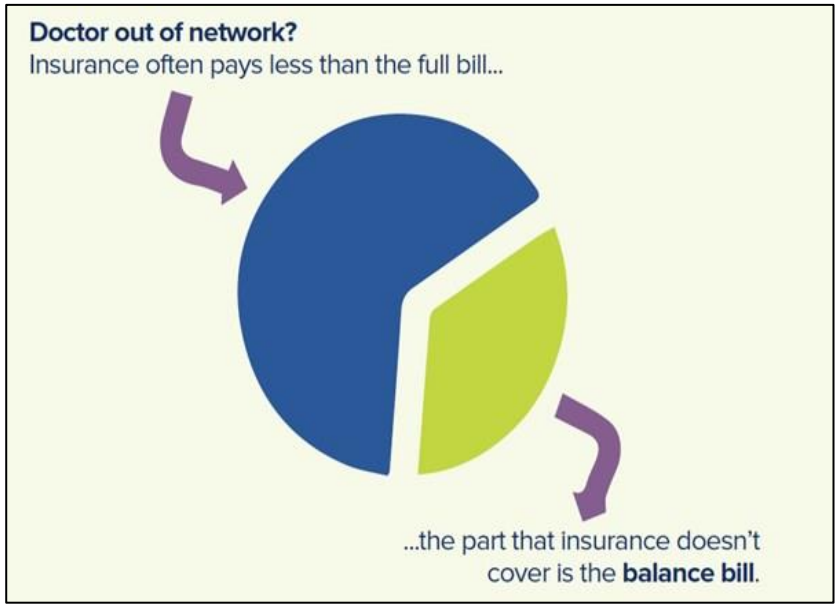
What Is A “Surprise Balance Bill”?

- A “balance bill” comes as a surprise for many people. A surprise medical bill is an unexpected bill from a health care provider or facility. Surprise billing usually occurs 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 situations.

- When individuals do not have an opportunity to select their in-network providers, their healthcare costs increase. Surprise billing is often used as leverage by providers to get higher in-network payments, which result in higher premiums, higher cost-sharing for consumers and increased health care spending overall.

- Although some states have enacted laws to reduce or eliminate balance billing, these efforts have created a patchwork of consumer protections. Even in a state that has enacted protections, they obviously are only applicable to individuals enrolled in health insurance coverage.

- Federal law generally preempts state laws that regulate self-insured group health plans sponsored by private employers. In addition, states have limited power to address surprise bills that involve an out-of-state provider.



When Does The No Surprises Act Become Effective?

The regulations are applicable to group health plans and health insurance issuers for plan and policy years beginning on or after January 1, 2022.

- The HHS-only regulations that apply to healthcare providers, facilities and providers of air ambulance services are applicable beginning on January 1, 2022.
- The OPM-only regulations that apply to insurance carriers under the FEHB program are applicable to contract years beginning on or after January 1, 2022.
- The rules regarding the certification of IDR entities and SDR entities are effective from the date the rule is published in the Federal Register.

Glossary

Emergency Care – for the purposes of these IFRs, "Emergency Care" is defined as:

- An appropriate medical screening to determine if an emergency medical condition exists
- Further medical examination and treatment to stabilize the individual.
- Pre-stabilization services provided after the patient is moved out of the emergency department and admitted to the hospital
- Post-stabilization services

Prudent Layperson Standard – Under this standard, a claim for emergency services must be covered if treatment is sought due to:

"A medical condition [including mental health or substance use disorders] of sufficient severity (including severe pain) such that a prudent layperson, who possesses an average knowledge of health and medicine, could reasonably expect that the absence of immediate medical attention could result in a condition

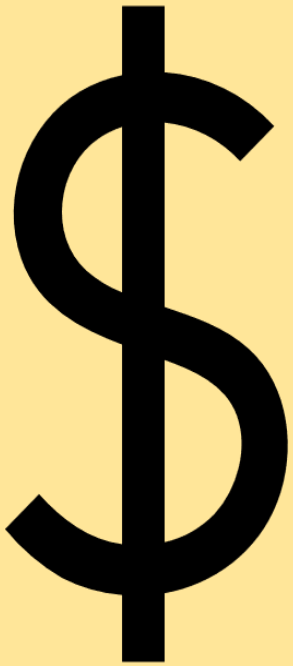
- placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
- serious impairment of bodily functions,
- serious dysfunction of any bodily organ or part."

Glossary

Qualifying Payment Amount – The qualifying payment amount (QPA) is a calculation that may apply to cost-sharing calculations as well as the Independent Dispute Resolution process.

The QPA is one of the amounts that may be used to calculate the member's cost sharing for out-of-network emergency services, out-of-network air ambulance services, and non-emergency services provided by out-of-network providers at certain in-network facilities.

The QPA is generally the median in-network contracted rate that the plan pays for the items or services at issue. If a plan does not have sufficient information to determine their median contracted rate, they can use a database free from conflicts of interest to determine the QPA.



Requirements Related to Surprise Billing; Part I

How Will Providers Be Paid?

The new rules do not require health plans to pay providers based on billed charges. Instead, a new set of rules will determine what the in-network rate "should be" for out-of-network services. The same will hold true for determining participant cost-sharing versus provider payments.

For participant cost sharing, the "in-network rate" is:

- The amount determined by an applicable All-Payer Model Agreement. These are agreements that certain states, most notably Maryland, have reached with the Centers for Medicare & Medicaid Services (CMS) that set specific pricing which all payers in the state abide by.
- If no All-Payer Model Agreement exists, the amount is determined by state law.
- If neither of those methods are applicable, it's the lesser of the actual billed charge or the "qualified payment amount," which is generally the plan's median contracted rate.

How Will Providers Be Paid?

Health plans have 30 days from the date they receive a bill from an out-of-network provider/facility to send a payment or deny the claim.

If the provider/facility does not accept the health plan's payment as payment in full, the parties have 30 days to resolve the matter privately.

If the health plan and provider/facility do not resolve the billing issue within 30 days, the health plan must pay the provider/facility based on the "in-network rate" calculation for determining participant contributions.

If the provider/facility does not accept this additional payment as payment in full, the final payment amount will be determined by an independent dispute resolution (IDR) process.

Notice and Consent Rules

Post-stabilization services can revert to out-of-network rates if certain conditions are met, and the provider/facility gives notice that they are out-of-network and receive informed consent to continue treatment. Certain out-of-network providers at in-network facilities can also charge out-of-network rates if they follow these procedures.

The provider/facility must:

- State that they are out-of-network
- Include a good faith estimate of the amount that will be charged for the services
- Indicate that the estimated charges do not constitute a contract
- Provide information about whether prior authorization or other care management requirements may apply
- State that the patient is not required to provide consent and that they may instead seek treatment from an in-network facility/provider

Notice and Consent Rules

To be considered valid, the notice must:

- Be provided separately from, and not attached to any other documents
- Be written and provided on paper, or electronically as selected by the patient
- Be provided at least 72 hours before the appointment (if the appointment is made 72 hours or more in advance) or, on the day the appointment is made and at least 3 hours before services are rendered (if the appointment is made less than 72 hours before services are to be provided).
- Be signed (including by electronic signature) by the patient or their authorized representative
- Include the date notice was provided and the date and time at which the consent was signed
- Be provided to the patient in-person, or through mail or e-mail as selected by the patient.

Requirements Related to Surprise Billing; Part II
The Independent Dispute Resolution (IDR)

IDR – The Process

Step 1	The Health Plan issues an initial payment or a denial of payment to the provider/facility. That payment or denial must include a statement informing the provide that the two parties may initiate a negotiation within 30 business days. If that negotiation is unsuccessful, an independent dispute resolution process is available with instructions on how to contact the health plan, including a phone number and email address.
Step 2	The provider/facility accepts the payment as paid in full or they initiate an “open negotiation notice” within 30 business days. The notice must include: ▪ Information sufficient to identify the items or services at issue, including the date provided and service code ▪ The initial payment amount or denial of payment ▪ An offer of an amount the provider will accept ▪ Contact information for negotiating the claim.

IDR – The Process

Step 3	The parties agree to a payment amount within 30 business days or the 30 business days expire and the open negotiation period ends. After the open negotiation period ends, both parties have 4 business days to request an independent review through the independent dispute resolution (IDR) process. This is done via a new portal the government is creating.
Step 4	The parties agree to an IDR Entity, or one is assigned by the government. If the non-initiating party does not object to the IDR Entity requested within 3 business days, that IDR Entity is assigned. If the non-initiating party objects, the parties have 3 business days to agree to an IDR Entity. If the parties do not agree, an IDR Entity will be randomly assigned
Step 5	Within 10 business days after the selection of the IDR Entity, each party submits an “offer” to the IDR Entity. The offer must be expressed as both a dollar amount and a percentage of the QPA

IDR – The Process

Step 6	The IDR Entity must select the offer that is closest to the QPA unless there is some creditable evidence submitted by the parties that suggests that the QPA is materially different from an appropriate out-of-network rate. For these purposes, the IDR Entity may not take into account: ▪ Usual and customary charges ▪ Medicare reimbursement rates
Step 7	The IDR entity provides a written decision to the parties and the Federal government. It must include the rationale for the IDR Entity's decision.
Step 8	The health plan pays the provider any balance due within 30 calendar days from the date the IDR Entity issues its written decision.

The IDR Entity's decision is binding on all parties.

What Should Plan Sponsors Do?

Because it is unlikely that surprise billing prohibition will be delayed (even though there were calls to do so), for fully insured plans, the insurance carriers will be responsible for ensuring compliance with these new rules.

Employers need not take any action at this time. Self-funded plan sponsors are legally responsible for ensuring compliance. They should work closely with their claims' administrators in the coming months to ensure the plan is compliant and participants will get appropriate notifications.

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Questions?