Surprise Billing Interim Final Rules: Key Policies

Overview

As part of the Consolidated Appropriations Act of 2021 (CAA), the *No Surprises Act* created federal protections for consumers against unexpected medical bills when they:

- Receive **emergency services** from either in-network or out-of-network providers and facilities
- Receive **post-stabilization care** following the emergency services described above, unless a patient waives protections through a notice-and-consent process
- Receive **non-emergency services** from out-of-network providers at in-network facilities, without appropriate notice and consent
- Receive **air ambulance services** furnished by out-of-network providers

In addition to prohibiting "balance billing," the *No Surprises Act* creates a **new final-offer arbitration process** to determine how much insurers may pay out-of-network providers, and requires **"good faith estimates"** be provided to uninsured and self-pay patients prior to furnishing services. The Departments of Health and Human Services (HHS), Labor and Treasury and the Office of Personnel Management released interim final rules (IFRs) to implement provisions of the *No Surprises Act,* the Surprise Billing Part 1 IFR (published July 13) and the Surprise Billing Part 2 IFR (published October 7). Premier's detailed summaries are available here for the Part 1 IFR and here for the Part 2 IFR.

Key provisions from the Interim Final Rules:

- Established a Federal independent dispute resolution (IDR) process to determine out-of-network payment amounts
- Specified selection criteria for IDR to use in making payment amount determinations
- Codified protections for consumers from unexpected medical bills
- Created notice-and-consent process to allow consumers to waive protections
- Codified requirements for providing good faith estimates for uninsured or self-pay patients and established a patient-provider dispute resolution process

Guidelines for Payer-Provider Negotiations and Disputes Involving Out-of-Network Payment Rates

In the absence of All-Payer Model Agreement rates or rates specified in state law, providers and payers negotiate payment amounts for out-of-network rates for items/services covered under the *No Surprises Act*.

Open negotiation. Payers must make an initial payment or send notice of denial no later than 30 calendar days after a provider/facility submits a clean claim. There is no federal statutory or regulatory minimum amount for the initial payment amount. Either party may initiate an open negotiation period within 30 business days of initial payment/denial. Open negotiation lasts up to 30 business days.

Independent Dispute Resolution Process.

- IDR initiation: After open negotiation ends, if there is no agreement either party can initiate an IDR process within 4 business days. A *Notice of IDR Initiation* must be submitted through the federal IDR portal. Parties jointly select an IDR entity to arbitrate the dispute, or HHS will randomly select an IDR entity. IDR entities will set their own fees, within a range identified by HHS based on IDR processes in states (presently $300-$600).
- IDR information submission: Within 10 business days of IDR selection, each party must submit a payment offer, both as a dollar amount and as a percentage of the QPA (see below). Additional required information includes the practice/facility size and specialty, health plan coverage area and type of coverage. Parties may submit additional information, such as hospital teaching status and acuity/complexity of patient treated, to justify their payment offer.
- IDR determinations**:** The IDR entity must select one of the offers within 30 business days of IDR selection. *IDR entities are required to choose the offer* ***closest to the QPA***, unless other credible information suggests the QPA is materially different from the appropriate payment amount.

Decisions are binding on both parties. Payment is due within 30 calendar days after determination. No enforcement mechanism for late payments is specified. Determination results (payment amounts, identities of parties, etc.) must be posted quarterly on a public website.

Qualifying Payment Amount (QPA).

- Definition: The QPA is defined as *the median of the payer's contracted rates for similar items/services, provider specialty, geographic region, and insurance market (e.g., individual, small group, large group).* In cases of insufficient data or new services/codes, payers may utilize alternative data sources, such as state all-payer claims databases or third-party databases, to obtain rates to calculate the QPA.
- Rates excluded from QPA calculation: Single case agreements and retrospective payment adjustments (e.g., shared savings payments) are excluded from median rate calculations. Notably, value-based arrangements using an underlying fee schedule typically include significant discounts on payment, with the opportunity to earn retrospective payment adjustments based on performance. Exclusion of retrospective payments may artificially lower the QPA. *Premier has advocated for removing value-based arrangements from QPA determinations and handling any disputes involving these contracts differently rather than defaulting to the QPA as an appropriate rate.*
- How QPA is used: The QPA is the primary factor considered by IDR entities in determining appropriate out-of-network payment amounts. The QPA also plays a role in calculating patient cost-sharing amounts for items and services protected under the *No Surprises Act*.

Consumer Protections from Surprise Medical Bills

For *group health plans* or *issuers of individual or group health coverage*, the following consumer protections apply:

Coverage of Emergency Services. Plans may not limit what constitutes an "emergency medical condition" based solely on diagnosis code or restrict coverage based on timing of symptom onset. Prior authorization is not permitted, and coverage may not be subject to whether a provider or facility is in-network. Coverage also cannot be limited solely on the basis of the final diagnosis code(s).

Cost-Sharing Protections. Cost-sharing may not exceed in-network rates for emergency services (including post-stabilization), and non-emergency services furnished by out-of-network providers at in-network facilities, or air ambulance services furnished by out-of-network providers. Patient payments must count towards in-network deductibles and out-of-pocket maximums.

Cost-Sharing Calculation Methodology. Cost-sharing must be calculated on the rates set by All-Payer Model agreements, amounts set in state law, or the lesser of the billed amount or the ***qualifying payment amount (QPA),*** in order of precedence. Consumers are financially shielded from outcomes of payer-provider payment disputes.

Notice and Consent for Waiving Protections. Consumer protections for cost-sharing and balance billing do not apply if an individual is provided notice and gives consent to accept out-of-network charges for non-emergency and post-stabilization services. In order to execute informed consent, providers/facilities must provide the following:

- Statement that provider/facility is out-of-network, also disclosing any limitations the patient's health plan may have if they waive *No Surprises Act* protections (e.g., prior auth)
- "Good faith estimate" of charges to the patient for required items or services
- Clear statement that the individual is not required to consent to receiving care from out-of-network provider or facility
- List of any in-network providers at the facility, options for referral

In order to execute informed consent, notice must be provided at least 72 hours before scheduled appointments, or if scheduled same-day, at least 3 hours prior to furnishing items or services. The notice

and consent process does not apply to emergency services, non-emergency services "where surprise bills are likely to occur" (e.g., services related to emergency services, such as anesthesiology), or urgent, unforeseen medical needs treated by out-of-network providers.

Good Faith Estimates for Uninsured and Self-Pay Patients

The *No Surprises Act* requires providers/facilities to inquire about health insurance status and whether patients will file claims for services through their health plan. If requested, or if items/services are scheduled, the provider/facility must provide a good faith estimate of charges, including items or services provided by other providers/facilities. The good faith estimate must contain an itemized list of items/services (grouped by provider/facility), applicable diagnosis codes, expected service codes, charges, and other information identifying patient and providers.

Required timelines:

- Must contact all co-providers and co-facilities within 1 business day to collect good faith estimate information. Co-providers/facilities must respond with their estimate within 1 business day of request.
- Must provide estimate to patient no later than 1 business day after scheduling when item/service is scheduled at least 3 business days in advance, no later than 3 business days after scheduling when item/service is scheduled at least 10 business days in advance, and no later than 3 business days after requested if no item/service is scheduled.
- If expected charges change, a new good faith estimate must be provided no later than 1 business day before the appointment.

Due to time required for providers/facilities to set up systems to comply, **HHS will exercise enforcement discretion on good faith estimates that lack expected charges from other co-providers/co-facilities.**

Provider-Patient Dispute Resolution. For uninsured or self-pay patients billed $400+ in excess of good faith estimate, the patient may initiate dispute resolution process within 120 calendar days of receiving the bill.

- Patient must file dispute initiation notice via Federal IDR portal, pay $25 fee (estimated). HHS selects Selected Dispute Resolution (SDR) entity, which will notify patient and provider/facility that case is under review
- SDR entity requests provider/facility provide copies of good faith estimate and total billed charges and explanation of difference between two amounts within 10 business days
- SDR entity must presume good faith estimate is appropriate amount, unless provider/facility demonstrates that billed charges reflect costs of medically necessary items/services that could not have been anticipated
- If the billed charge is justifiably higher than good faith estimate, patient will pay **the lesser of** billed charge or median payment amount paid by plan/issuer for similar item/service, provider and geography (i.e., the QPA)

Note: Providers/facilities must suspend or defer bill collection during dispute resolution and refrain from retributive actions against patients.

Policy Provisions Subject to Future Rulemaking

Additional price transparency requirements were included in the *No Surprises Act*, intended to be effective January 1, 2022. Per an FAQ released by the Departments, provisions for which enforcement will likely be delayed, pending additional rulemaking and/or guidance, include:

- ID card information requirements
- Requirement that providers/facilities produce a good faith estimate" for treatment for patients who file health insurance claims

- Advanced Explanation of Benefits requirement for payers upon receiving “good faith estimate” from providers/facilities
- Prohibition of gag clauses in contracts that restrict payers from sharing information as required by statute
- Provider directory accuracy and accessibility requirements

The Departments have also delayed enforcement on key parts of the Transparency in Coverage rule until July 1, 2022 (originally slated to begin 1/1/2022) in order to give plans more time to comply. The new enforcement date applies to the requirement that certain plans disclose online their in-network provider rates, out-of-network allowed amounts and billed charges for certain items and services. Any plan year that begins after July 1 must post the files in the month in which the plan year begins.

The Departments will also issue regulations soon on reporting requirements for drug costs and pharmacy benefits, as required by the CAA. The Departments will defer enforcement on those reporting requirements as well, pending rulemaking, but urge payers to begin preparing to report data by December 27, 2022 (one year after original initial reporting deadline).