No more surprises for out-of-network bills:

The No Surprises Act (NSA) was signed into law Dec. 27, 2020, as part of the Consolidated Appropriations Act, 2021. The Departments of HHS, Labor and the Treasury along with the Office of Personnel Management then issued two interim final rules (IFRs) implementing requirements related to surprise billing under NSA.

Part I outlines price transparency criteria, cost-sharing requirements and patient financial protections. Part II explains the arbitration process for billing disputes between out-of-network (OON) providers and insurers and the good faith estimate (GFE) requirements for uninsured and self-pay patients. Both IFRs impact health plans, providers and facilities, effective Jan. 1, 2022.

NSA amends the Public Health Service Act, ERISA, Internal Revenue Code and the law governing the Federal Employees Health Benefits Program to prohibit surprise bills, including OON cost-sharing and balance billing amounts for individuals covered by group health plans and health insurance issuers of group and individual health plans when receiving emergency and post-stabilization services furnished by a non-participating provider or non-participating facility and non-emergency services furnished by non-participating providers in participating facilities.

NSA holds patients liable only for their in-network cost-sharing amount while allowing OON providers and health plans an opportunity to negotiate reimbursement and seek an independent dispute resolution process (IDR) if there are any discrepancies about reimbursement.

Regulations described in the IFRs are applicable to healthcare providers, facilities and the following entities:

- Group health plans, including insured and self-insured plans and private employment-based groups subject to ERISA.
- Non-federal government plans.
- Individual health insurance coverage, including coverage offered in the individual market, through or outside an exchange and student health insurance.
- Grandfathered and grandmothered plans. Grandfathered plans are an individual or group health insurance plan purchased on or before March 23, 2010. They may offer the same benefits and consumer protections as required by the ACA, and they never have an expiration date. Grandmothered plans were effective after March 23, 2010, before implementation of the ACA. These plans have different requirements with compliance based on various aspects of the ACA. They have an expiration date, but insurers continue to make extensions.
- Indemnity plans.
- Carriers in the Federal Employee Health Benefits Program.

Provider requirements

Both IFRs establish requirements for healthcare providers and facilities to provide a GFE of expected charges to patients considering or scheduling care. A GFE is a notification of expected charges for a scheduled or requested service, including service rendered in conjunction with the primary service from other providers or facilities participating in the patient's care.

Healthcare providers and facilities also will be required to make publicly available, post on a public website (if applicable) and provide a one-page notice to individuals regarding:

- Balance-billing requirements and prohibitions that apply to a provider or facility.
- Any applicable state balance-billing requirements.
- How to contact appropriate state and federal agencies if the patient believes the provider or facility has violated the requirements in IRF.

In addition, IFRs outline a process by which a patient may receive notice. The process also potentially provides consent to receive OON care and forgo the financial protections of NSA. If the patient does not consent, NSA protections remain in place. The departments have issued standard notice and consent documents, including sample forms and templates, available at CMS.gov/NoSurprises.

Transparency with providers and payers

Part I of NSA explains the qualifying payment amount (QPA) or the amount a payer would reimburse an OON provider for an item or service.

Explaining surprise billing and why it matters

According to the rule, payers must disclose the following to providers:

- QPA for each item or service.
- Contact information to initiate open negotiations to determine an amount of payment, including cost-sharing.
- A statement certifying QPA applies to the recognized amount and is determined in compliance with methodology in IFR.
- A statement that the provider or facility may initiate a 30-day open negotiation to determine the payment and, if the 30-day period does not result in a final determination, the provider or facility may initiate the IDR process within four days.
- Upon the request of the provider or facility, information about whether QPA included contracted rates not set on a fee-for-service basis and whether QPA was determined or derived from using underlying fee schedule rates.

Part II establishes an IDR process for a provider, facility, plan or issuer who feels QPA is unfairly calculated and wishes to initiate an open negotiation. The party initiating the open negotiations must provide written notice (open negotiation notice) to the other party of its intent to negotiate. The departments will provide a standard notice form that will include the following requirements:

- The date the service was furnished
- The service code(s)
- Initial payment amount or notice of payment denial
- An offer for the OON rate
- Contact information of the party sending the notice

A timeline of the negotiation and dispute resolution process is provided in the CMS Part II Fact Sheet at CMS.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period.

NSA also establishes a patient-provider dispute resolution process, under which an uninsured or self-pay patient may seek a determination from an IDR entity for the amount to be paid by the patient to the provider. Under Part II, a patient may request such a determination if he or she is billed for an amount that is "substantially in excess" – at least $400 more than the GFE of expected charges furnished by the provider."

Patient protections

IFR itemizes patient protections to alleviate the challenges patients may face from experiencing a difficult medical situation and, in turn, a financial hardship from unexpected bills. Included are protections from:

- Surprise billing for emergency services, regardless of location.
- High OON cost-sharing for emergency and non-emergency services by keeping costs no higher than in-network rates.
- OON charges for ancillary care at any in-network facility.
- Other OON charges without advance notice.

In addition, if a patient's health plan covers any benefits for emergency services, IFR requires non-participating emergency services to be covered:

- Without any prior authorization.
- Regardless of whether a provider or facility is in-network.
- Without limitations.

More information about requirements and protections relating to the IFRs, including an overview of rules, fact sheets as well as additional polices and resources, can be found on CMS.gov. ■