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No Surprises Act (Medical Billing)

No Surprises Act

Disclaimer #1:

- The presentation is a general overview to an area of law.
- Nothing in this presentation should be interpreted as legal advice.
- Participation in this presentation **does not** create an attorney-client relationship.
- Contact your attorney with questions or for implementation guidance.

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Disclaimer #2:

- The published rules implementing the law are “interim” final rules (likely to change) or proposed rule (also likely to change).

- Additional guidance from regulatory agencies is likely to be published as implementation of the law continues to roll out and regulators continue to receive feedback from providers, plans and employers.

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Statutory/Regulatory Background

- Law: Part of Consolidated Appropriations Act of 2021 passed in December 2020
- Three Interim Final Rules: (July 2021) patient cost-sharing protections (balance billing), notice and consent standards for waivers, rules for calculating the qualifying payment amount*, disclosure requirements; (Oct. 2021) independent dispute resolution (IDR) procedures, good faith estimate requirements, patient dispute resolution procedures; (Nov. 2021) requirements for group health premium information plans and issuers to submit certain information about prescription drug and healthcare insurance premium information
- Proposed Rules: (Sept. 2021) reporting requirements (for air ambulances, plans and insurers), compensation disclosure rules for insurers, enforcement provisions
- Guidance/FAQ'S

*Stay tuned for future slide addressing Texas case limiting the qualified payment amount

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Why was it adopted?

- To address balance billing
  - Air ambulances, in particular, have created a lot of attention in this area as they predominantly “out of network” providers
- To provide patients with information to be consumer advocates
- Bipartisan support
- Inconsistent state regulation; limitations on ability of states to regulate self-insured plans

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Who does it regulate?

- Private insurance (fully-insured) (*e.g.,* BCBS, Cigna, Aetna)
- Self-insured plans (employer sponsored)
- Healthcare facilities and providers, including physicians
- Air ambulance providers
- Does not apply to federal payors or services provided to Medicare/Medicaid patients

NOTE: This presentation focuses on regulations applicable to healthcare providers.

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How does it interact with state law?

- Many states had adopted rules to protect patients from surprise billing before adoption of federal law, but with limited scope.

- Federal law does not trump more protective/restrictive state law (similar to HIPAA)

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How does the law propose to protect patients?

- **Patient Protection.** Intended to address total costs of care provided by out-of-network providers in emergency cases or care from out-of-network providers at in-network facilities (limitations on balance billing).
- **Patient Education.** Requirements to provide both Patient Notice & Good Faith Estimate to inform patients of cost of care in advance for non-emergency medical care.

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How does it impact physician groups?

- **Patient Protection:** Most likely to impact (i) facility-based providers (anesthesiology, radiology, pathology, ER), (ii) surgeons/other doctors providing services in a facility, and (iii) post-acute services provided by physicians.

- **Patient Education:** All physician groups must comply with the requirement to post Patient Notice and to provide Good Faith Estimate to uninsured/self-pay patients.

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Patient protection:

- **Limitations on Balance Billing – when it applies:**
  - Patient seeks *emergency* care at an out-of-network facility
  - Patient seeks care at an in-network facility (emergency or non-emergency), but providers (such as anesthesia, radiology, surgery) or services (such as labs) are out-of-network

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Patient protection (continued):

- **Limitations on Balance Billing – how it applies:**
  - For emergency care, out-of-network provider cannot bill more than the patient's in-network cost-share amount
  - In some cases involving non-emergency care, out-of-network providers can balance bill the patient with advance written consent
    - Otherwise limited to (i) billing patient for in-network cost-share amount and (ii) negotiated payment from insurer

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Patient protection (continued):

- **Consent to balance bill for non-emergency care by out-of-network provider at in-network facility:**

  Exception to allow to bill with consent does not apply to:

  – Ancillary services, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
  – Items and services provided by assistant surgeons, hospitalists, and intensivists
  – Diagnostic services including radiology and lab services
  – Items and services provided by an out-of-network provider if there is not another in-network provider who can provide that service in that facility

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Patient protection (continued):

- **Consent to balance bill for non-emergency care by out-of-network provider at in-network facility:**
  - **MUST use the form of consent developed CMS**
  - Very technical requirements regarding content
  - Must include a good-faith estimate
  - Typically consent must be obtained at least 72 hours in advance
  - Patient can revoke at any time prior to service

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Patient protection (continued):

- Payment to provider (beyond the patient's in-network cost sharing responsibility and no consent to balance bill) determined by:
  - Agreement between provider and insurer, or
  - Independent dispute resolution process
- A penalty of up to $10,000 for each violation can apply

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Patient protection (continued):

- **Independent Dispute Resolution (IDR) Process:**
  - Plan/Insurer makes initial payment
  - 30-day open negotiation period if provider does not accept initial payment as payment in full
  - If negotiations fail, either party can invoke IDR process
  - Certified IDR Arbitrator determines final payment amount

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Patient protection (continued):

- **Independent Dispute Resolution (IDR) Process (continued):**
  - Certified IDR Arbitrator:
    - List available on CMS website, including fees ($300 - $500 for single claims), losing party pays the fee
    - Bundled process of appeals available
    - “Baseball” arbitration (arbitrator must select one of the proposals – no “meeting in the middle”)

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Patient protection (continued):

- **Independent Dispute Resolution (IDR) Process (continued):**
  - Parties must submit payment proposal within 10 days of selection of arbitrator
  - Parties can submit additional information for arbitrator to consider
  - Can consider: provider level of training/expertise, quality outcomes, patient acuity, party's market share in geographic region
  - Cannot consider: public (M/M) payment rate
  - 90 day no-repeat period

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Patient protection (continued):

- **Independent Dispute Resolution (IDR) Process (continued):**
  - Qualifying Payment Amount Proposal (no longer applies):
    - Regulations provided a method to calculate the "Qualifying Payment Amount" (median rate the insurer would have paid for the service if provided by an in-network provider or facility)
    - Default rule was that arbitrator would select the offer in arbitration that was closest to Qualifying Payment Amount (other permitted factors could sway this decision)
    - Recent case in TX eliminated the presumption that the "qualifying payment amount" was a reasonable payment amount in the dispute resolution process. Ruling has left other open questions regarding process.

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Patient Education:

- Following requirements apply to all providers, regardless of whether in-network or out-of-network, and regardless of where services are provided

- Two Separate Requirements:
  - Patient Notice
  - Good Faith Estimate for uninsured/self-pay (including patient/provider resolution process)

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Patient Education:

- **Patient Notice**
  - Inform patients regarding
    - Balance billing protections
    - Right to receive a Good Faith Estimate
    - How to report violations
  - Posted/Provided:
    - On website
    - Where individuals schedule care, check-in for appointments, or pay bills, unless the provider doesn't have a publicly accessible location
- **CMS Form of Notice**

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Patient Education:

- **Good Faith Estimate Content:**
  - Must include:
    - Good faith estimate of all charges for all care (not just by the provider/facility preparing the GFE)
    - Expected services
    - Diagnosis Codes
  - Recent (April 5, 2022) guidance issued by CMS addressing content requirements in specific situations (such as when you do not yet have a diagnosis)

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Patient Education:

- **Good Faith Estimate Timing:**
  - **CMS sample form**
  - Must be provided earlier of (i) 3 days after requested, or (ii) at least 3 business days in advance of services (but within 3 business days of scheduling if scheduled date is 10 or more days in advance, within one business days if scheduled date is within 3 and 9 days)
  - Process/timing for updates

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Patient Education:

- **Good Faith Estimate/Convening Provider:**
  - The provider or facility who schedules an item or service or who receives the initial request for a good faith estimate from an uninsured (or self- pay) individual
  - Required to solicit information from other providers (hospital, anesthesia provider, laboratory) necessary to provide the Good Faith Estimate
  - Other providers (the co-provider/co-facility) must provide requested information for GFE to the convening provider within one business day

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Patient Education:

- **Good Faith Estimate/Dispute Resolution Process:**
  - Dispute resolution process of actual billed amounts are more than $400 over estimate on the GFE
  - Process is initiated by patient or representative sending notice to HHS within 120 days of receiving initial bill
  - Selected Dispute Resolution (SDR) entity appointed to review whether the provider or facility has provided credible information that justifies the difference between the bill and the estimate for each unique item or service charged

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Timeline

- **December 27, 2020:** Passage of Consolidated Appropriations Act of 2021 (No Surprises Act was part of this legislations)

- **2021:** Publication of interim final rules and proposed rule by regulatory agencies.
  - Department of Labor
  - Department of Treasury (IRS)
  - Department of Health and Human Services (CMS)

- **2021 and ongoing**: Regulatory guidance

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Timeline

Jan. 1/Feb. 1, 2022

- Billing Rules (out-of-network providers)
- Patient Notices
- Good Faith Estimate (advance notice of total costs) for uninsured patients/self-pay patients
  - Provided by the healthcare provider
  - Enforcement discretion for providers that make a good faith effort to comply but cannot include all costs from other providers involved in care

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Timeline (continued)

January 1, 2023:

- Good Faith Estimates for privately-insured patients (including self-insured employers, but not M/M)
- Commencement of random audits of healthcare providers (approx. 200/month)
- Expiration of “enforcement discretion” for Good Faith Estimates for uninsured/self-pay plans (must now include costs from all providers)

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Who will enforce?

- States have the primary role to enforce No Surprises Act rules against all healthcare providers, with federal government as backup.
- CMS and NC have a "collaborative enforcement agreement" pursuant to which (i) NC will perform compliance functions/investigations and seek voluntary compliance with respect to specific provisions that the state does not have legal authority to enforce, and (ii) if NC is unable to obtain voluntary enforcement, then CMS will be responsible for formal enforcement action against a health care provider
- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-Enforcement-Letters-North-Carolina.pdf

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Real World Implications:

- Letter sent by BCBS NC to certain hospital-based providers and emergency services providers.
- Proposed that in-network providers could accept lower in-network rates or go out-of-network (where reimbursement would be subject to IDR arbitration process)
- Sent prior to Texas case throwing out the Qualifying Payment Amount process

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Forms:

- **Patient Notice/Required Disclosures:** https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf
- **Good Faith Estimate:** https://www.cms.gov/files/document/good-faith-estimate-example.pdf
- **Consent to Bill Out of Network:** https://www.cms.gov/files/document/standard-notice-consent-forms-nonparticipating-providers-emergency-facilities-regarding-consumer.pdf
- **Patient-Provider Resolution Process (Notice of Patient Settlement):** Appendix 10 - PPDR Payment Settlement Form Notice (cms.gov)

[All will be posted after presentation on NC Medical Society website.]

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Resources:

CMS Link to Regulations, FAQ's and Guidance:

- https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance#No_Surprises_Act
  - Under "Regulations and Guidance", select "No Surprises Act"
  - Recent FAQ = FAQ Part 2 addressing GFE (April 5, 2022) https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ-Part-2.pdf

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COMMENTS, QUESTIONS & STORIES

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