AANA | FREQUENTLY ASKED QUESTIONS

Federal Requirements Related to Surprise Billing As Part of the No Surprises Act

Overview

With passage of the No Surprises Act, starting January 1, 2022, consumers now have new billing protections when getting emergency care or non-emergency care from out-of-network providers at in-network facilities. The law has created new rules aimed to protect consumers, excessive out-of-pocket costs will be restricted, and emergency services must continue to be covered without any prior authorization, regardless of whether a provider or facility is in-network. This Frequently Asked Questions (FAQ) document aims to inform CRNAs of these new requirements and how they affect CRNA practice.

What is the No Surprises Act?

Congress passed the No Surprises Act as part of the Consolidated Appropriations Act of 2020 and in January 2022, the new law went into effect limiting "surprise" medical bills, or bills insured patients receive for out-of-network care, either in emergency settings, or from out-of-network providers at in-network facilities. The No Surprises Act imposes requirements on health care facilities, providers, and group health plans or health insurance issuers offering group or individual health insurance coverage with emergency services, non-emergency services provided by out-of-network providers at in-network facilities and air ambulance services. These requirements do not apply for services payable by Medicare, Medicaid, the Children's Health Insurance Program, or TRICARE, as each of these programs already has other protections in place against unanticipated medical bills.

What is the background/ history behind this Act?

Most group health plans and health insurance issuers that offer group or individual health insurance coverage have a network of providers and health care facilities (in-network providers) that agree to accept a specific payment amount for their services. Many times, providers and facilities that are not part of a plan or issuer network (out-of-network or "OON" providers) usually charge higher amounts than the contracted rates the plans or issuers pay to in-network providers.

Prior to January 1, 2022, consumers received surprise medical bills if they had health coverage and got care from an out-of-network provider. Their health plans usually did not cover the entire out-of-network cost. This left them with higher costs than if they had been seen by an in-network provider. This is especially common in an emergency situation where consumers might not be able to choose the provider. Even if a consumer goes to an in-network hospital, they might get care from out-of-network providers at that facility.

In many cases, the out-of-network provider bills consumers for the difference between the charges the provider bills, and the amount paid by the consumer's health plan. This is known as balance billing. An unexpected balance bill is called a surprise bill.

Which agencies have jurisdiction over this law?

Federal agencies have issued rulemaking to help aid healthcare providers and facilities and health plans to comply with the Act's requirements. The Department of Health and Human Services (HHS), the Department of Labor and the Department of the Treasury (collectively the Departments), along with the Office of Personnel Management (OPM), have issued rules listed below that outline requirements for providers and facilities:

What rules have been issued on the No Surprises Act?

On July 13, 2021, the Departments and OPM issued "Requirements Related to Surprise Billing; Part I," a rule that:

- Bans balance billing for emergency services in an emergency department, including ancillary services routinely available to the emergency department to evaluate emergency medical conditions. Cost-sharing for emergency services must be determined on an in-network basis.
- Requires that patient cost-sharing, such as copayments, co-insurance, or a deductible, for emergency services and certain non-emergency services provided at an in-network facility cannot be higher than if such services were provided by an in-network provider, and any cost-sharing obligation must be based on in-network provider rates.
- Prohibits OON charges for items or services provided by an OON provider at an in-network facility, unless certain notice and consent is given. This notice and consent

stipulation does not relate to anesthesia providers delivering anesthesia services as they are strictly prohibited from billing for OON charges. However, chronic pain CRNAs delivering chronic pain services could conceivably bill for OON charges as long as they provide notice and consent. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent is required to receive care on an OON basis before that provider can bill the patient more than in-network cost-sharing rates.

- CRNAs should know that if out-of-network providers bill an individual in violation of these requirements, they may be subject to civil fines or other corrective action.

Review the Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period fact sheet

On September 10, 2021, the Departments and OPM released a rule to implement the following provisions of the No Surprises Act to establish:

- New reporting requirements regarding air ambulance services;
- New disclosures and reporting requirements regarding agent and broker compensation;
- New procedures for enforcement of Public Health Service Act (PHS Act) provisions against providers, health care facilities, and providers of air ambulance services;
- New disclosure and reporting requirements applicable to issuers of individual health insurance coverage and short-term, limited-duration insurance regarding agent and broker compensation; and
- Revisions to existing PHS Act enforcement procedures for plans and issuers.
- CRNAs should know that the requirements under this regulation apply primarily to air ambulances and have little relevance for them.

Review the Air Ambulance rule – Fact Sheet

On September 30, 2021, the Departments and OPM issued interim final rules called "Requirements Related to Surprise Billing; Part II" that outlines the federal independent dispute resolution process, good faith estimate requirements for uninsured (or self-pay) individuals for non-emergency care, the patient-provider dispute resolution processes for uninsured (or self-pay) individuals for non-emergency care, and external review provisions of the No Surprises Act.

Independent Dispute Resolution

The September 30, 2021 rule establishes as of January 1, 2022 the federal independent dispute resolution (IDR) process that out-of-network (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.

- The open negotiation period can be 30 business days, but either party can initiate the federal IDR process during this 30-day period as well. Not all items and services are eligible for the federal IDR process.
- The federal IDR provisions may be used to determine the out-of-network rate for certain emergency services, nonemergency items and services furnished by nonparticipating providers at participating health care facilities, and air ambulance services furnished by nonparticipating providers of air ambulance services except where an All-Payer Model Agreement or specified state law applies.
- Group health plans and health insurance issuers in the group and individual market may use the IDR process following the end of an unsuccessful open negotiation period to determine the out-of-network rate for certain services.
- In the event the parties do not reach an agreement, the parties must still exhaust the 30-business-day open negotiation period before either party may initiate the IDR process. The Departments encourage parties to negotiate in good faith during this time period to reach an agreement on the OON rate. To the extent parties reach agreement during this period, they can avoid the administrative costs associated with the IDR process.
- The parties then may jointly select a certified independent dispute resolution entity (certified IDR entity) to resolve the dispute. In order to jointly select a certified IDR entity, the plan or issuer and the nonparticipating provider, nonparticipating emergency facility, or nonparticipating provider of air ambulance services must agree on a certified IDR entity not later than 3 business days after the date of initiation of the Federal IDR process. If the parties fail to agree on a certified IDR entity, the Departments will randomly select a certified IDR entity.
- After a certified IDR entity is selected, the parties will submit their offers for payment, which is a dollar amount and the percentage of qualifying payment amount (QPA) that is generally based on the median of contracted in-network rates established through negotiations between providers and facilities and plans and issuers (or their service providers), along with supporting documentation and any additional credible information they feel is necessary to support their offers. Providers cannot provide the "usual and customary" charges or previous billed amounts as an offer.
- The certified IDR entity must look first to the QPA, as it represents a reasonable market-based payment for relevant items and services, and then to other considerations to determine a rate.
- A written decision of the certified IDR entity must be submitted to the Departments, and if the certified IDR entity does not choose the offer closest to the QPA, the report must include a detailed explanation of the additional considerations relied upon, whether the information submitted by the parties was credible, and the basis upon which the certified IDR entity determined that the credible information demonstrated that the QPA is materially different from the appropriate out-of-network rate.
- The Departments state that their best interpretation of the statute is that a certified IDR entity must look first to the QPA and then to other considerations in determining the rate. The presumption that the QPA [median rate] is the appropriate OON rate can then be rebutted by credible information about additional circumstances that clearly demonstrate that the QPA is materially different from the appropriate out-of-network rate. The Departments state that the statute provides relatively limited guidance on how to consider the additional circumstances, but sets out detailed rules for calculating the QPA, suggesting that an accurate and clear calculation of the QPA is integral to the application of consumer cost-sharing and to determination of the out-of-network rate.
- The Departments also state that choosing an out-of-network rate higher than the offer closest to the QPA,

simply based on the level of experience or training of a provider, would lead to an increase in prices without a valid reason, and this does not align with the goals of the No Surprises Act.

- 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 according to the CMS fact sheet), and the non-prevailing party is responsible for the certified IDR entity fee for the use of this process. The rule estimates that the average IDR entity fee to be about $400 and there may be a separate fee for batched services amounts.
- If the offer selected by the certified IDR entity is less than the sum of the initial payment and any cost sharing paid by the participant, beneficiary, or enrollee, the provider, facility, or provider of air ambulance services will be liable to the plan or issuer for the difference.

Good Faith Estimates for Uninsured (or Self-pay) Individuals – Requirements for Providers and Facilities

- When scheduling an item or service, or if requested by an uninsured or self-pay individual, providers and facilities 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. They must tell the individual who schedules an item or service at least 3 business days before the date such item or service is to be so furnished, not later than 1 business day after the date of such scheduling.
- The provider or facility must provide a notification in clear and understandable language of the good faith estimate of the expected charges for furnishing the items or services listed on the good faith estimate with the expected billing and diagnostic codes for any such items or services. This estimate must also include items or services that may be provided by other providers and facilities. For example, for a 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 operation.
- CRNAs should be aware that this good faith estimate requirement does not apply to emergency services.

Patient-Provider Dispute Resolution

- After being given the good faith estimate, if the patient is billed an amount that is "substantially in excess" of the expected charges in the good faith estimate, the patient may seek a determination from a selected dispute resolution (SDR) entity of the amount to be paid to the provider or facility within 120 days of receiving the bill. "Substantially in excess" is defined as more than $400 of the total dollar amount.
- CRNAs might be involved in the patient provider dispute process if they bill a service considered "substantially in excess." CRNAs should be aware that if the actual charges exceed $400 of the bill due to the procedure being more severe than anticipated, the bill will still be considered "substantially in excess."
- SDR entities will make payment determinations as part of the patient-provider dispute resolution process. The patient-provider dispute resolution process has timelines for documentation submission and payment determination, and participating individuals will be charged an administrative fee. To ensure the administrative fee does not act as a barrier for consumers accessing dispute resolution, the fee will be set at $25 in the first year and will be updated through sub-regulatory guidance in future years.

Review the fact sheet on the interim final rules

Is there a list of the AANA's comment letters on these rules?

Please see the following comment letter area on the AANA's Federal Government Affairs Division.

Is there a list of federal agency guidance for further information on the No Surprises Act?

The following federal agency guidance has been released related to the No Surprises Act:

CMS Overview of Rules on No Surprises Act and Fact Sheets

Overview of CMS Disclosures, Notice and Consent Forms

- Standard notice & consent forms for nonparticipating providers & emergency facilities regarding consumer consent on balance billing protections

Download Surprise Billing Protection Form PDF

- Model disclosure notice on patient protections against surprise billing for providers, facilities, health plans and insurers

Download Patient Rights & Protections Against Surprise Medical Bills PDF

- Requirements for including federal agency contact information and website URL on certain documents

Download Memo of Requirements for Plans, Providers and Facilities PDF

FAQs about Consolidated Appropriations Act, 2021 Implementation- Federal Independent Dispute Resolution System, Notice and Consent, Applicability

These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of the Federal Independent Dispute Resolution system and Notice of Consent requirements.

FAQs about Consolidated Appropriations Act, 2021 Implementation - Good Faith Estimates

These FAQs have been prepared by the Department of Health and Human Services (HHS) to address the provision of GFEs for uninsured (or self-pay) individuals, as described in Public Health Service Act (PHS Act) section 2799B-6 and implementing regulations at 45 CFR 149.610.

Qualifying Payment Amount (QPA) Calculation Methodology

The QPA is the basis for determining individual cost sharing for items and services covered by the No Surprises Act under certain circumstances.

Patient-Provider Dispute Resolution Guidance

These guidance documents provide additional details

on the Good Faith Estimate (GFE) and Patient-Provider Dispute Resolution (PPDR) process for uninsured/self-pay consumers, provider facilities, and Selected Dispute Resolution Entities. The guidance also provides Calendar Year 2022 information on the PPDR administrative fee.

List of Certified Independent Dispute Resolution Entities

The Department of Health and Human Services, the Department of Labor, and the Department of Treasury have certified these organizations to serve as independent dispute resolution entities in the federal independent dispute resolution process between providers, facilities or providers of air ambulance services and group health plans, health insurance issuers and Federal Employees Health Benefits program carriers. The Departments are continuing to receive and review applications and will update this list with additional independent dispute resolution entities as they are certified.

CMS Overview of No Surprises Act Provider and Facility Requirements

Providers With Technical Questions about Provider Requirements for the No Surprises Act should reach out to **provider_enforcement@cms.hhs.gov**

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