Moore&VanAllen

ALERTS

Health Care Client Update: No Surprises Act

01.2022

Background:

On January 1, 2022, two Interim Final Rules (the "Rules") that implement key aspects of the No Surprises Act ("NSA") became effective. The first Interim Final Rule was initially issued by the U.S. Departments of Health and Human Services ("HHS"), Labor, and Treasury, and the Office of Personnel Management (collectively, the "Departments") on July 1, 2021. The second, issued by the same agencies, was issued on October 7, 2021. Generally, the NSA, which was signed into law on December 27, 2020, (1) limits cost-sharing and prohibits balance billing in certain situations and (2) requires providers to provide good faith estimates ("GFE") of charges to uninsured or self-pay patients. The NSA and the Rules also establish notice and consent requirements and dispute resolution processes in both instances.

Disclosure Notice:

Each health care provider and facility must make publicly available, post on a public website, and provide to any patient enrolled in a group health plan or group or individual health insurance coverage a one-page notice explaining the balance billing requirements under the NSA. The disclosure must include the following:

- the requirements of and prohibitions applicable under the NSA to the health care provider or facility;
- any state law requirements regarding the amounts such provider or facility may charge a patient for receiving services from a nonparticipating provider or facility; and
- contact information for the appropriate State and Federal agencies that an individual may contact if the individual believes the provider or facility has violated a requirement described in the notice.

Limits on Cost Sharing and Prohibition of Balance Billing:

- Applicable Plans and Issuers:

The prohibitions on balance billing and cost sharing limitations under the NSA and the Rules apply to the following: (1) group health plans; (2) health insurance issuers offering group or individual health insurance coverage; and (3) carriers in the Federal Employees Health Benefits Program.

- Applicable Scenarios Where Cost Sharing Limits Apply:

The prohibitions on balance billing and cost-sharing limitations apply to the following scenarios: (1) emergency services provided by a nonparticipating facility or provider; (2) non-emergency services provided by a non-participating provider at a participating facility; and (3) air ambulance services furnished by a non-participating provider.

- Cost Sharing Amounts:

In all three scenarios described above, the NSA and the Rules prohibit balance billing by mandating that the cost-sharing requirement cannot exceed the requirement that would apply if such services were provided by a participating provider, and any such cost-sharing payments made must be applied towards any in-network deductible or out-of-pocket maximums as if such services were provided by a participating provider.

For Scenarios 1 and 2 described above, the cost-sharing amount is calculated as if the total amount that would have been charged by the participating provider were equal to the "recognized amount." The "recognized amount" is: (1) an amount determined by an applicable All-Payer Model Agreement under § 1115A of the Social Security Act ("APMA"); (2) if there is no applicable APMA, then an amount determined by specified state law; or (3) if there is no applicable APMA or a specified state law, then the lesser of the amount billed or the Qualifying Payment Amount ("QPA").[1] For Scenario 3 (air ambulance services), the cost-sharing amount is calculated as if the total amount were equal to the lesser of the billed amount or the QPA.

- Notice & Consent Exception to Cost Sharing Amounts:

An exception to the balance billing protections of the NSA is available for nonemergency services if the provider furnishes certain notice to the patient and the patient consents to receiving the service. This exception does not apply to ancillary services as defined under 45 C.F.R. §149.420(b) (e.g., diagnostic services, including radiology and laboratory services). With respect to emergency services, the notice and consent exception applies if the attending physician determines that the individual is able to travel to a participating provider or facility within a reasonable distance and the attending physician determines the individual is in a condition to receive the notice and provide consent. If the provider or facility gives sufficient notice under the Rules and the beneficiary refuses to consent, the provider or facility may refuse to furnish services, but will be subject to balance billing protections for services rendered subsequent to the notice without consent.

The notice must be in writing and provided together with the consent document physically separate from any other documents. Certain information must be included in the contents of the notice,[2] and use of the standard notice document provided by HHS guidance in accordance with its instructions (see here) is considered good faith compliance. If an individual schedules an appointment for services at least 72 hours in advance, the provider or facility must provide notice at least 72 hours prior to the appointment. If an individual schedules an appointment within 72 hours, the provider or facility must give notice on the day the appointment is made. If notice is provided on the same day as the appointment, the notice must be provided at least three hours prior to the furnishing of services.

In addition to being provided separately with the notice document, the consent must be voluntary and signed by the individual or their authorized representative. The contents of the consent must include certain information,[3] and use of the standard consent document specified by HHS in guidance in accordance with its instructions (see here) is considered good faith compliance. An individual may revoke consent at any time prior to the furnishing of items or services by notifying the provider or facility in writing, in which case the balance billing protections apply as if the consent was never provided.

- Out-of-Network Rate:

The total amount paid by the plan (less any cost sharing payments) to the provider or facility is: (1) an amount determined by an applicable APMA; (2) if there is no APMA, then the amount determined by a specified state law; (3) if there is no APMA or a specified state law, then the agreed upon amount between the plan or issuer and the provider or facility. If all three of these conditions fail, then the parties enter into the Independent Dispute Resolution ("IDR") Process. The plan or issuer is responsible for any difference in the out-of-network rate and cost sharing amount paid by the beneficiary, even if the beneficiary has not met their deductible.

- Independent Dispute Resolution Process:

If the out-of-network rate cannot be determined by an applicable APMA or a specified state law, and the plan or issuer and the provider or facility cannot agree upon an amount, then the parties enter into the IDR process provided for by the Rules. Prior to entering into the IDR process, the parties enter into a 30-business day open negotiation period, which is triggered by receipt of an open negotiation notice sent by one party to the other. The notice must be sent within 30 days of the initial payment or notice of denial and must use the standard form developed by the Departments (see here).

If the open negation period fails, either party may initiate the IDR process by submitting a written notice of IDR initiation to the other party and to the Departments through the Federal IDR portal, using the standard form developed by the Departments (see here), during a 4-business-day period beginning the day after the open negotiation period closes. Within the written notice, the notifying party indicates their preferred certified IDR entity, and if the parties cannot agree on the certified IDR entity, the Departments select the certified IDR entity. Once the IDR entity is chosen, the parties have 10 days to submit payment offers and additional information to the IDR entity, and a payment determination is made within 30 business days after the IDR entity is selected. Parties may reach their own agreement any time prior to the IDR entity making a payment determination.

Good Faith Estimate Requirements for Uninsured or Self-Pay

- Which Patients and When:

Health care providers and facilities are required to furnish a GFE of the expected charges for items or services provided upon scheduling of an item or service for an uninsured or self-pay patient or upon the request for a GFE by an uninsured or self-pay patient. If the service is scheduled at least three business days in advance, the provider must furnish the GFE within one business day of scheduling. If the service is scheduled at least 10 days in advance, the provider must furnish the GFE within three business days of scheduling. If a GFE is requested, the provider must furnish it within three business days. At scheduling or upon request, the health care provider must inquire whether the patient has medical insurance and whether the patient will submit a claim if they are insured. The provider is responsible for informing all uninsured and self-pay patients of the availability of a GFE.[4]

- Convening Provider v. Co-provider:

The provider or facility that receives the GFE request or schedules the primary service or item is called the "convening provider." The convening provider is responsible for providing the GFE to the patient. The convening provider is also responsible for providing a new GFE to the patient if the convening provider anticipates or is notified of any changes in the scope of services. A co-provider or co-facility is a provider that furnishes services that are customarily in conjunction with the primary item or service. The convening provider must contact all co-providers reasonably expected to furnish services within one business day of receiving a GFE request or scheduling a primary service, and co-providers must provide the convening provider with GFE information within one business day of receiving the request. Importantly, the incorporation of co-provider information into GFEs is subject to enforcement discretion through December 31, 2022.

- Good Faith Estimate Requirements:

Under the 45 C.F.R. 610(c), the GFE must contain many specific elements, including without limitation, an itemized list of items or services reasonably expected to be provided for the primary service and any services provided in conjunction, grouped by each provider or facility. The GFE must also describe the primary item or service in clear and understandable language and include a disclaimer that the GFE is not a contract and does not require the patient to obtain the items or services identified in the GFE.

- Patient-Provider Dispute Resolution:

The GFE also must include a disclaimer that the patient can initiate the patient-provider dispute resolution process if the actual amount billed is substantially in excess of the GFE. A patient may initiate the dispute resolution process by submitting an initiation notice to HHS within 120 calendar days of receiving the initial bill for charges that are substantially in excess of the GFE. Once the patient submits the initiation notice through the FDR portal, HHS will select a dispute resolution entity (the "SDR"). After being selected the SDR notifies both parties that the dispute resolution request has been received and is under review. Within 10 business days of receiving this notice, the provider must submit to the SDR: (1) a copy of the GFE; (2) a copy of the billed charges; and (3) if available, documentation that the difference between the GFE and the billed charge reflects the cost of a medically necessary item or service that could not reasonably be anticipated. Within 30 days of receiving this information, the SDR makes a payment determination. At any time prior to the payment determination, the parties are free to negotiate their own settlement.

Conclusion

The No Surprises Act and the Rules that implement it are complex and can create many compliance challenges for health care providers. For furnishing GFEs, "convening" providers will have to develop operations to coordinate with "co-providers" to quickly receive cost estimates for services reasonably expected to be provided in conjunction with the primary service or item. Providers also need to understand how the NSA and its Rules intersect with state laws. The NSA merely creates a floor for balance billing protections and does not supplant existing state law protections (unless the protections are weaker). For example, All-Payer Model Agreements or other state laws in place will generally control determining cost sharing and out-of-network rates. Furthermore, providers need to implement safeguards for identifying situations in which balance billing protections attach as each instance in which a patient is billed in violation of the NSA can result in a penalty up to $10,000. Providers should have processes in place for identifying every patient that is subject to the

protections of balance billing and making sure such patients are given a one-page notice and made aware of their protections.

[1] In general, the QPA is the median of the contracted rates recognized by the plan or issuer on January 31, 2019, adjusted according to the methodology provided under 45 C.F.R. 149.140.

[2] The notice must: (1) state that the health care provider is nonparticipating provider; (2) include the good faith estimated amount that such nonparticipating provider may charge the individual for the items and services involved (including those reasonably expected to be involved); (3) make clear that the good faith estimate nor the individual's consent to be treated, does not constitute a contract; (4) provide information about whether prior authorization or other care management limitations may be required; (5) clearly state that consent to receive such items or services from the nonparticipating provider or facility is optional; (6) in emergency services cases involving a participating facility and nonparticipating provider, include a list of participating providers at the facility able to furnish the services; and (7) in emergency services cases involving a nonparticipating facility, include the good faith estimated amount the individual may be charged for services furnished by the nonparticipating facility.

[3] The consent must: (1) state that the individual has been provided with the written notice; (2) state that the individual has been informed that payment made by the individual may not accrue towards meeting cost-sharing limitations, including in-network deductibles and out of pocket maximums; (3) state that the individual agrees to be treated by the nonparticipating provider; (4) state that the individual understands they may be balance billed and subject to cost-sharing requirements for services furnished by nonparticipating providers; and (5) include the times at which the individual received notice and signed the consent.

[4] The information must be:

- written in a clear and understandable manner, prominently displayed (and easily searchable from a public search engine) on the convening provider's or convening facility's website, in the office, and on-site where scheduling or questions about the cost of items or services occur; (B) orally provided when scheduling an item or service or when questions about the cost of items or services occur; and (C) made available in accessible formats, and in the language(s) spoken by individual(s) considering or scheduling items or services with such convening provider or convening facility.

45 C.F.R. 149.610.