SURPRISE BILLING

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Agenda

- Brief Review of Interim Final Rules
- Recent Developments
- Implementation Strategies
- Questions?

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The “No Surprises Act”

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- **Passed by Congress in late 2020 as part of the broader Consolidated Appropriations Act (CAA)**
  - Intends to largely eliminate surprise billing, particularly in the emergency department setting
  - Patient liable only for in-network cost-sharing amount
  - Establishes an independent dispute resolution (IDR) process for settling reimbursement disputes between payors and providers
  - Implements price transparency requirements for payors, including an advanced EOBs, and more accurate provider directories

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July 2021 Interim Final Rule

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- **First *in series* of regulations implementing No Surprises Act**
  - Eliminates surprise billing for emergency services and out-of-network ancillary services at an in-network facility
  - Establishes Qualifying Payment Amount (QPA) – for determining patient cost-sharing obligations
  - Implements a patient notice-and-consent process for **narrow** exceptions to surprise billing protections, as well as public disclosure requirements for providers

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July 2021 Interim Final Rule

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- **Primary impacted entities**
  - Payors: Commercial group health plans (small group, large group, individual), including grandfathered plans
    - » **Excludes** excepted benefits, short-term limited-duration plans, health reimbursement arrangements (HRAs), and account-based group plans, **as well as Medicare Advantage (MA)** and Medicaid managed care plans
  - Providers: Hospitals, CAHs, ASCs, freestanding EDs (including urgent care centers, air ambulance providers, physicians)

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Non-emergency services

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- **When provided by an out-of-network provider at an in-network facility, must…**
  - Be covered without patient cost-sharing obligation beyond what they would pay for in-network services
  - Count toward in-network deductible and out-of-pocket maximum

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Notice and Consent

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- **Disclosures must…**
  - *Be made utilizing HHS model disclosure notice form*
    - ***Note: Complaints to you first?***
  - Be posted online and in a prominent place in the facility
  - Be provided to the patient in paper or electronic format

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Notice and Consent

- **Model Notice →**

Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called "**balance billing**." This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

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Notice and Consent

- **Model Notice (cont.), with suggestions →**

If you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
  - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
  - Cover emergency services by out-of-network providers.
  - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
  - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

For billing questions, you may reach a [ABC Hospital] financial services representative by calling [555-555-5555], [Monday-Friday, 8 a.m. – 5 p.m.].

If you believe you've been wrongly billed under U.S. law, you may contact the U.S. Department of Health & Human Services at 1-800-985-3059 or by visiting https://www.cms.gov/nosurprises/consumers

Visit https://www.cms.gov/nosurprises/consumers for more information about your rights under federal law.

For Tennessee patients: If you believe you've been wrongly billed, you may also contact the Tennessee Department of Commerce & Insurance (TDCI) at 1-800-342-4029.

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Example of Enforcement Letter

- https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA-Enforcement-Letters-Georgia.pdf

DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

December 13, 2021

The Honorable Brian Kemp
Governor of Georgia
State Capitol
206 Washington Street
Suite 203
Atlanta, GA 30334

Commissioner John King
Department of Insurance & Fire Safety
2 M.L.K. Jr. Dr., SE #716
Atlanta, GA 30334

Dear Governor Kemp and Commissioner King:

The purpose of this letter is to inform you that the Centers for Medicare & Medicaid Services (CMS) understands that Georgia has authority and intends to enforce certain provisions of the Public Health Service Act (PHS Act) as extended or added by the Consolidated Appropriations Act, 2021 (CAA) with respect to health insurance issuers, health care providers, facilities, and providers of air ambulance services, and that CMS has agreed to enter into a collaborative enforcement agreement with Georgia to enforce certain other PHS Act provisions extended or added by the CAA in Georgia with respect to health insurance issuers, health care providers, facilities, and providers of air ambulance services. This letter also reflects CMS's understanding that the Georgia independent dispute resolution and federal patient-provider dispute resolution processes will apply. Additionally, this letter reflects CMS's determination that plans and issuers in Georgia will continue to use the Federal external review process to address adverse determinations related to the surprise billing protections of the No Surprises Act under section 2719 of the PHS Act, as extended by Section 110 of the No Surprises Act, consistent with 45 CFR 147.136, as amended by the Requirements Related to Surprise Billing; Part II (86 FR 55980).

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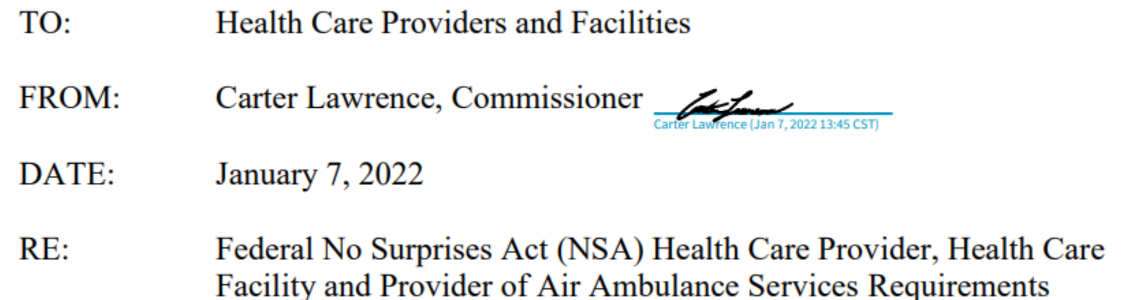
Tennessee Developments

- **Bulletin 22-01 from Commissioner Carter Lawrence →**
  - Notifying health care providers and facilities of the requirements in the No Surprises Act

STATE OF TENNESSEE
DEPARTMENT OF COMMERCE AND INSURANCE
500 JAMES ROBERTSON PARKWAY
NASHVILLE, TENNESSEE 37243-5065
615-741-6007

BILL LEE
GOVERNOR

CARTER LAWRENCE
COMMISSIONER



BULLETIN 22-01

TO: Health Care Providers and Facilities

FROM: Carter Lawrence, Commissioner

Carter Lawrence (Jan 7, 2022 13:45 CST)

DATE: January 7, 2022

RE: Federal No Surprises Act (NSA) Health Care Provider, Health Care Facility and Provider of Air Ambulance Services Requirements

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Notice and Consent (cont.)

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- **Disclosures must…**
  - – Include all applicable surprise billing requirements and limitations (including state law)
    - In January, the Tennessee state Senate passed SB0001, which would require the commissioner of commerce and insurance to establish an independent dispute resolution process by which a dispute for a bill for out-of-network billing emergency services or balance bill may be resolved.
    - **To date, this bill has not been passed by the Tennessee State House*
      - – *Similar to Georgia IDR process…confusion!*

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Recent Developments

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- **Rule For IDR Process (September 30, 2021)**
  - Required QPA be main factor in rate setting
- **Rule Impacting Group Health Plan and Insurers (November 17, 2021)**
  - Prescription Drug and Health Care Spending

https://www.cms.gov/nosurprises/Policies-and-Resources/Overview-of-rules-fact-sheets

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Recent Developments

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- **Good Faith Estimates**
  - Required as of January 1, 2022
  - Enforcement Discretion Regarding GFE for insureds
  - Must give GFE to uninsured
  - Timing (at least 1 day in advance, generally 3 days if 10 days or more in advance)
  - Sample forms on CMS website

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Payment to Provider

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- **Health Plan Payment**
  - Insurer may make initial payment to provider
  - If provider determines payment inadequate, then 30-day negotiation period to agree on amount, ELSE
  - Either party may use IDR process
    - Entities that can be used for IDR identified on CMS website
    - **QPA is the primary basis for rate-setting**

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Qualifying Payment Amount (QPA)

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- **Patient cost-sharing obligation calculated utilizing the recognized amount, defined as the lesser of the amount billed by the provider/facility or the QPA**
  - The median of the contracted rates recognized by the plan or issuer on January 31, 2019, for the same or similar item or service that is provided by a provider in the same or similar specialty and provided in a geographic region in which the item or service is furnished, increased for inflation" each year.
- **The QPA will be a foundational element in future payor/provider discussions in the IDR (arbitration) process to be outlined in future rulemaking.**

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Recent Developments

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- **Litigation Regarding the IDR Process**
  - Litigation by providers in Texas, Georgia, District of Columbia Regarding rulemaking process for IDR process
  - The November 2021 IDR rule required QPA be main factor in rate setting
  - Does not apply to
    - ancillary services, including items and services related to emergency medicine

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DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information and Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

Memorandum Regarding Continuing Surprise Billing Protections for Consumers

Date: February 28, 2022

On February 23, 2022, the United States District Court for the Eastern District of Texas, in the case of *Texas Medical Ass'n, et al. v. United States Department of Health and Human Services, et al.*, Case No. 6:21-cv-425 (E.D. Tex.), invalidated portions of an interim final rule, Requirements Related to Surprise Billing; Part II, 86 Fed. Reg. 55,980 (Oct. 7, 2021) (the "Rule"), issued by the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") governing aspects of the federal independent dispute resolution (IDR) process under the No Surprises Act.

This court's order *did not* affect any of the Departments' other rulemaking under the No Surprises Act. **Thus, consumers continue to be protected from surprise bills for out-of-network emergency services, out-of-network air ambulance services, and certain out-of-network services received at in-network facilities.** The patient-provider dispute resolution process for uninsured and self-pay consumers to dispute bills that exceed a provider's or facility's good faith estimate by $400 or more also remains available and unchanged by the court's order. To learn more about these protections, visit www.cms.gov/nosurprises.

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CMS Update – 2/23/2022 Call

- CMS has already begun to receive complaints
- CMS will enforce NSA UNLESS the individual state specifies that it will do so
  - MOUs on CMS website
  - Information on whether state or federal rules apply for Dispute Resolution
- CMS Confirms that NSA does not apply to SNFs (facility)
  - Confirms that NSA applies to providers in the identified facility settings
    - Providers can contract with facility to provide notices on their behalf
- CMS: If patient has recurring course of treatment, provider MUST give notice/ consent each time

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CMS Update – 2/23/2022 Call

- Website posting
  - No need to create website if do not have one
  - Must be "accessible" without login requirements
- Law does NOT apply for noncovered services, e.g., cosmetic procedures
- Disclosures can be done via mail, email or in person
  - Patient can decide how to receive information

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CMS Update – 2/23/2022

- Continuity of Care Requirements
- Provider Directory Requirements
- Public Disclosure Requirements

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Other Developments

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- Mayo Clinic dispute with United Healthcare Medicare Advantage Plan
  - Mayo Clinic will no longer schedule appointments for out-of-network patients
  - Primary issue is “capacity, not reimbursement”
  - By 2023 Half or Medicare Beneficiaries in MA plans?
- Payor errors in billing OON ED patients
  - Not using in-network rates
- Payor pressures to transfer patients?

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Other Developments

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- Antitrust litigation in Louisiana with BCBS regarding rates
- Litigation over contract termination – Northside Hospital in Georgia
- Other litigation

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Additional Information

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- No Surprises Act Information:
  - https://www.cms.gov/nosurprises
  - FAQs for Providers About the No Surprises Rules:
    - https://www.cms.gov/nosurprises/policies-and-resources/provider-requirements-and-resources

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