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*Advancing Health in America*

# No Surprises Act Interim Final Regulations

All Member Webinar  
July 21, 2021

# Key Provisions for Discussion Today

- ✓ Ban on Certain Balance Billing
- ✓ Notice and Consent Process for Certain Out-of-network Services
- ✓ Calculation of the Qualifying Payment Amount
- ✓ Initial Payment to Providers
- ✓ Disclosure Requirements
- ✓ Interaction with State Law
- ✓ Oversight

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2<sup>nd</sup> AHA All-member  
Webinar on the Interim  
Final Regulations on  
August 3<sup>rd</sup>

# Scope of Policy



## Types of Health Care Coverage

- Federal Employees Health Benefits Program
- Individual and small group markets
- Group health plans, including grandfathered health plans



## Types of Providers

- Facilities: Hospitals, hospital outpatient departments, critical access hospitals, and ambulatory surgical centers
- Independent freestanding emergency departments
- Air ambulance providers
- Other health care providers, such as physicians and ancillary care providers

# Patient Protections Against Balance Billing

- As of January 1, 2022, providers/facilities may not balance bill out-of-network patients for:
  - Emergency services, including certain services post-stabilization
  - Professional services when delivered at in-network facilities
  - In \*some\* instances, providers may seek patient consent to balance bill



Ban does not apply to scheduled services when both the facility and provider are out-of-network.

# Definition of Emergency Services

- Appropriate medical screening examination and any such further examination and treatment as is required to stabilize the individual
- Services provided after stabilization until transfer, discharge, or patient consents to balance bill

The ban applies regardless of where in the hospital the services are provided and when provided by a freestanding emergency department.



# Post-stabilization: Conditions to Transfer or Obtain Consent

## Transfer

1. Sufficiently stable to travel using nonmedical transportation or nonemergency medical transportation, as is determined by the attending emergency physician or the treating provider

## Obtain Consent

1. Sufficiently stable to travel using nonmedical transportation or nonemergency medical transportation, as is determined by the attending emergency physician or the treating provider.
2. The attending physician or treating provider determine the individual or the individual's personal representative is able to provide informed consent
3. The provider or facility satisfies other conditions laid out by the departments; and
4. The providers and facilities comply with any relevant state law, including laws that prohibit patients from waiving balance billing protections.

**More information on the consent process coming up.**

# Limits on Professional Out-of-Network Billing

- Out-of-network providers performing services at in-network facilities may not balance bill patients for any items and services, including equipment, devices, telemedicine services, imaging services, laboratory services and pre-and-post operative services.
- Certain providers may seek the patient's consent to balance bill for certain scheduled services.



# Notice and Consent: Process General Requirements



- As noted, consent is only an option for certain types of providers and types of services
- Patient must be able to freely give consent
- Providers must adhere to certain timelines and use a standard form
- Providers must retain forms for a certain period of time and share the forms with both the patient and their health plan (which facilities may do for providers upon mutual agreement)
- Providers must notify plans when balance billing protections apply for a service and when notice and consent is used.

Once given, a patient may revoke their consent in writing and before the item or service is delivered.



# Limits on Providing Notice and Obtaining Consent

## Consent cannot be used for:

- X Items and services related to emergency medicine, anesthesiology, pathology, radiology and neonatology, whether provided by a physician or non-physician practitioner;
- X Items and services provided by assistant surgeons, hospitalists and intensivists;
- X Diagnostic services, including radiology and laboratory services; and
- X Other items and services provided by a nonparticipating provider if there is no participating provider who can furnish such items or services at such facility.

Consent does not extend to items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which consent was received.

# Notice and Obtaining Consent Standard Form

## The form must include:

- The name of the out-of-network provider or facility
- The provider's contact information
- A good faith estimate of charges
- Information on any care management limitations that may be imposed by the patient's health plan/issuer
- The contact information for appropriate state and local agencies to report any potential violations

Forms must be available in the 15 most common languages in the provider's area.

# Standard Notice and Consent Forms Provided by HHS

## Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

**IMPORTANT:** You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You shouldn't sign this form if you didn't have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

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## Estimate of what you could pay

Patient name: \_\_\_\_\_

Out-of-network provider(s) or facility name: \_\_\_\_\_

Total cost estimate of what you may be asked to pay:	_____
------------------------------------------------------	-------

- ▶ Review your detailed estimate. See Page 4 for a cost estimate for each item or service you'll get.
- ▶ Call your health plan. Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- ▶ Questions about this notice and estimate? Call [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]
- ▶ Questions about your rights? Contact [contact information for appropriate federal or state agency]

### Prior authorization or other care management limitations

[Enter either (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

### Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

### More information about your rights and protections

Visit [website] for more information about your rights under federal law.

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## By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

[doctor's or provider's name] [If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider]

[facility name]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [enter date of notice] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

**IMPORTANT:** You don't have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

\_\_\_\_\_  
Patient's signature or Guardian/authorized representative's signature

\_\_\_\_\_  
Print name of patient or Print name of guardian/authorized representative

\_\_\_\_\_  
Date and time of signature or Date and time of signature

Take a picture and/or keep a copy of this form.  
It contains important information about your rights and protections.

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# Notice and Consent: Timeline & Process

- Notice and Consent must be sought at least 72 hours before the service or treatment is to be delivered.
- For same-day services, notice and consent must be sought at least three hours prior to receiving the service or treatment.
- Providers/facilities must convey the forms to the patient separately from other documents.
- A copy of the signed notice and consent form must be provided to the patient or authorized representative in a form of their choosing.
- In addition, a representative of the provider/facility must be available to answer questions.

# Notice and Consent Scenarios

## Scenario #1

Can a patient sign consent for out-of-network services for the services of a surgical assistant?

No, the No Surprises Act lists “assistant surgeons” as one of the ancillary services for which the notice and consent process cannot be used. While not specifically defined, we interpret this to include all forms of surgical assistants as this would align with the government’s stated intent.

## Scenario #2

In the case of a post-stabilization patient where the attending physician determines the patient can safely be transported to an in-network-facility by non-medical transport but there is no available transportation, can the provider seek consent to balance bill?

No. One of the conditions that has to be factored into a patient’s ability to willingly consent is access to an appropriate form of transportation (among other factors).

## Scenario #3

A patient has an out-of-network policy with their health plan and is seeking care at an in-network facility. One of the providers is out-of-network. Is notice and consent required when they have agreed to out of network care via their health plan policy?

Yes. A patient at an in-network facility must be presented with a notice and consent form and a good faith estimate of possible charges even if their health plan has an out-of-network provision.

**Providers are not required to treat the patient if the patient does not consent to be balance billed.**

# Initial Payment to Provider

- Plans/issuers must make an initial payment within 30 days of receiving a clean claim
- The amount must be a reasonable expectation of payment
- Plans are permitted to deny coverage and/or deny the claim, e.g., because the service is not covered or because some other requirement was not met (e.g., medical necessity)



The government seeks input on whether it should set a minimum standard for the reimbursement amount.

# Assessing Patient Cost-sharing

- Providers/facilities must bill the plan to ascertain the amount to bill patients
- That amount will be based on:
  - State law (whether all-payer state or other provision)
  - The qualifying payment amount (~/- the plan's average in-network reimbursement.



# Calculating the QPA

- The average of the plan's/issuer's 2019 rate trended forward (CPI-U):
  - Same insurance market/type of coverage
  - Same/similar item or service
  - Same/similar provider specialty
  - Whether delivered in a hospital ED or freestanding ED
  - In same geographic region (as defined by MSAs\*)
- Must have at least 3 rates available

How the QPA will be used in the arbitration process will be determined in future rulemaking.



# Disclosure Requirements

- Providers and facilities must make publicly available information on patients' rights with respect to balance billing, including through a notice to patients.

## Public Notice

- ✓ posted on website
- ✓ contain information on federal balance billing protections and applicable state-level protections
- ✓ include contact information for state and federal agencies to report any potential violations.

## Patient Notice

- ✓ one page notice to patients when provider or facility asks for payment or submits a claim

# Model Disclosure Notice Form

## 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 balance 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.

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.**

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

### 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.

If you believe you've been wrongly billed, you may contact *[applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws]*.

Visit *[website]* for more information about your rights under federal law.

*[If applicable, insert: Visit [website] for more information about your rights under [state laws].]*



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# Interaction with State Law

- In general, the regulations apply to all forms of commercial coverage except in instances where states have surprise medical billing protections in place for state-regulated plans.

## State Surprise Billing Laws

- ✓ Prohibition on Balance Billing
- ✓ Notice and Consent
- ✓ Authorized Patient Representative
- ✓ Post-Stabilization Applicable State-level Protections
- ✓ Cost Sharing Amount and Out of Network Rate
- ✓ Qualified Payment Amount

## ERISA Interaction

- ✓ Allow self-insured plans to opt in to a state program law that provides a method for determining the cost-sharing amount or total amount.
- ✓ Provide a number of scenarios to help identify when state versus federal law would apply, such as when the health plan license and the provider are in different states.

# Oversight

- QPA Audits
  - Departments will use existing processes for audits and enforcement
- Complaint Process
  - Single complaint process for any NSA violation concerns
  - Complaints will need to include information on all parties involved and the action/inaction subject to the complaint; departments may follow-up for more information
  - Departments have 60 days to respond with information on next steps, including:
    - Initiating an investigation for enforcement action
    - Referring the complaint to another state/federal resolution process or state/ federal authority with enforcement jurisdiction
  - No statute of limitation for filing complaints



**No new audit or enforcement mechanisms beyond the single complaint process**

# Issues Not Addressed in These Regulations

- Independent dispute resolution process
- Good faith estimates/advanced explanation of benefits
- Provider directories
- Continuity of Care

# Discussion: Ban on Balance Billing



- Are there scenarios in which confusion remains about whether a provider can balance bill or not?
- Should the 30-day clock for when plans need to make a payment to providers start when the provider sends a “clean claim?”
- Should the plans be required to pay providers a minimum amount for out-of-network services?
- Claims that are denied due to an “adverse benefit determination” are not subject to the No Surprises Act, while claims denied for other reasons may be adjudicated through the No Surprises Act rules (i.e., arbitration process). Are these distinctions clear enough?

# Discussion: Notice and Consent



- Are there scenarios where confusion remains about when notice and consent is permitted?
- Do you have any reaction to HHS's model notice and consent form and standard disclosure form?
- How do you anticipate complying with the requirement to include a “estimate in good faith” as part of the notice? What will that take, and is it more or less burdensome than the process of sharing this information with insurers (to comply with the No Surprises Act price transparency policies)?
- Are there concerns that the notice consent process could be a barrier care, such as the 3 hour time requirement for notice of out-of-network services for post-stabilization patients receiving same day care?

# Next Steps

- Next AHA Webinar: Aug. 3, 2021
- Comments Due to Departments by Sept. 7, 2021
- Questions/Comments/Feedback?
  - Molly Smith [mollysmith@aha.org](mailto:mollysmith@aha.org)
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