Vizient Summary: Surprise Billing Requirements for Healthcare Providers

The Consolidated Appropriations Act of 2021, which included the No Surprises Act (NSA), aims to protect consumers from surprise medical bills. The law contains several requirements for group health plans, health insurance issuers in the group and individual markets, providers, facilities, and air ambulance providers. Several regulations and resources have been released to implement the law, but more are anticipated. This summary provides an overview of requirements currently in place, various deadlines, resources, and considerations for future implementation that are most relevant to providers.[i]

Prohibitions on Balance Billing for Individuals using Insurance (Effective)

The following prohibitions on surprise billing or balance billing[ii] are currently in place:

- Emergency services from out-of-network providers
    - Out-of-network providers cannot bill or hold liable enrollees who received emergency services for a payment amount greater than the in-network cost-sharing requirement of their insurer.
- Non-emergency care from out-of-network providers at in-network facilities
    - Out-of-network providers cannot bill or hold liable enrollees who received covered non-emergency services at an in-network healthcare facility for an amount greater than the in-network cost-sharing requirement for those services, unless notice and consent requirements are met.
- *Note*: Under certain circumstances, patients may waive their balance billing protections, but the provider must provide notice to the patient and obtain consent.

Good Faith Estimates (Partially Effective)

Healthcare providers must ask enrollees about their health insurance prior to scheduling an item or service, since this will impact whether the provider needs to provide a good faith estimate (GFE) to the patient. Providers should be aware of different timelines to provide the GFE depending on when an item or service is scheduled. Providers and facilities must provide notice on patients' right to a GFE and the patient-provider dispute resolution (PPDR) process (effective).

- ***Uninsured and self-pay patients:*** Providers must give a GFE of expected charges to uninsured and self-pay patients in advance of a scheduled service, or upon request.[iii]
    - Patient Requests for a GFE: Any discussion or inquiry regarding potential cost should be treated as a request for a GFE. Providers should be aware of the PPDR process for charges substantially in excess (i.e., $400 or more) of the GFE (more below).
    - Scope of GFE: The GFE should provide an itemized list of items and services, grouped by each provider or facility, that is reasonably expected to be provided as part of the primary item or service along with those reasonably expected to be furnished in conjunction with the primary item or service for that period of care. As a result, the GFE could contain expected charges from multiple providers: the convening provider and co-providers or co-facilities that furnish items and services customarily provided in conjunction with a primary item or service – but this requirement is delayed.
        - On December 2, 2022, CMS again issued guidance further delaying enforcement of the requirement that GFEs include estimates from co-providers and co-facilities, pending future rulemaking. During this period of enforcement discretion, CMS has encouraged convening providers and facilities to include a range of expected charges for items and services reasonably expected to be provided and billed by co-providers and co-facilities.[iv]
    - Convening providers and facilities[v]: Convening providers and facilities must provide a GFE to uninsured (or self-pay) individuals within certain timeframes (as outlined on pg. 4 of this CMS guidance) (effective). For example, when a primary item or service is scheduled at least 3 or 10 business days before the date the item or service is scheduled to be furnished, the GFE must be provided no later than 1 or 3 business days, respectively, after the date of scheduling. Additionally, if a GFE is requested, it must be provided within 3 business days.

- ***Patients using insurance:*** As of January 2023, the GFE requirement that the provider submit to the plan or insurer a GFE of charges for each service is not currently in effect. As a result, the Advanced Explanation of Benefits (AEOB) requirements, which are described below, are also delayed and additional regulations are expected.

AEOB for Patients Using Insurance (Delayed)

When a patient using insurance schedules an item or service, the provider or facility must provide the plan with a GFE of the expected charges for the service, regardless of whether the services are in or out-of-network. Plans must then provide members with an AEOB upon receiving a GFE. The AEOB must include the network status of the provider or facility, the contracted rate for the service, the GFE from the provider, a GFE of the amount the plan is responsible for paying, and the cost-sharing amount. The AEOB must be issued within certain timeframes after the provider submits to the plan or insurer a GFE of charges for each service. As written in statute, the Departments were supposed to have implemented the AEOB requirements by January 1, 2022. However, these requirements remain delayed.

Independent Dispute Resolution Arbitration Process (Effective)

In the October 2021 interim final rule Requirements Related to Surprise Billing; Part II, the Department established an independent dispute resolution (IDR) process to determine out-of-network payment amounts between providers or facilities and health plans where payment is disputed[vi]. Following a lawsuit in the case of *Texas Medical Association (TMA), et al. v. United States Department of Health and Human Services*, a federal district court ruled in favor of health care providers and found that elements of the recently finalized surprise billing regulations related to the IDR process between providers and health plans were invalid. Following the decision, in August 2022, an updated final rule was released. However, providers remain concerned that the rule still gives outsized weight to the Qualifying Payment Amount (QPA) by requiring arbitrators to consider the QPA first in all cases, among other provisions. These regulations prompted an additional lawsuit from the TMA. On December 20, 2022, a federal district court heard arguments regarding the new final rule, but, as of January 3, 2023, a final decision has not yet been reached. The court's decision may force the administration to revise its IDR approach once again; however, the IDR process remains in effect. Notably, a large proportion of closed disputes in 2022 were found ineligible for the IDR process.[vii]

Patient-Provider Dispute Resolution (PPDR) Process (Effective)

The October 2021 interim final rule Requirements Related to Surprise Billing; Part II also implements various provisions of the NSA related to the PPDR process. The PPDR process aims to establish protections for uninsured (or self-pay) individuals who receive billed charges that are substantially in excess (more than $400) of the GFE. Under the PPDR process, the uninsured (or self-pay) individual may seek a determination from a Selected Dispute Resolution (SDR) entity for the amount the individual has to pay. No later than 30 business days after receiving this information, the SDR entity must determine the amount to be paid by the uninsured (or self-pay) individual. During this time, the two parties may agree to resolve the dispute by settling on a payment amount. Additional guidance on GFEs and the PPDR process is available.

Additional Requirements for Public Disclosures, Continuity of Care, and Provider Directories

- Providers and facilities must publicly disclose federal and state (if applicable) patient protections against balance billing (effective).[viii]
- Plans, providers, and facilities must ensure continuity of care when a provider's network status changes in certain circumstances (effective, but regulations have yet to be released; additional information is available here which indicates that providers and facilities are expected to implement the requirements using a good faith reasonable interpretation of the statute prior to issuing rulemaking).
- Plans, issuers, providers, and facilities must implement certain measures to improve the accuracy of provider directory information (effective, but regulations have yet to be released; additional information is available here which indicates that providers may have to work with health plans to make good faith efforts when these circumstances are reported).

Visit here for more information on frequently asked questions regarding the NSA. Please contact the Vizient Public Policy and Government Relations team at (202) 354-2600 or VizientGR@vizientinc.com with any additional questions.

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[i] For example, there are differing requirements based on whether the patient is uninsured (or self-pay) or using insurance and whether the provider is a convening provider or convening healthcare facility (for brevity, "convening provider" in this document) or co-healthcare provider (or co-healthcare facility) (for brevity, "co-provider" in this document).
[ii] The difference between the amount the provider charges and the amount the individual's plan will play plus the individual's cost-sharing amount
[iii] A standardized good faith estimate patient form is provided at this link.
[iv] CMS, The No Surprises Act's Good Faith Estimates and Patient-Provider Dispute Resolution Requirements, available here.
[v] The provider or facility who receives the initial request for a good faith estimate from an uninsured (or self-pay) individual and who is or, in the case of a request, would be responsible for scheduling the primary item or service.
[vi] For Q2-Q3 2022, there have been over 40,000 disputes initiated and only 23,107 disputes have been closed as of Sept. 30, 2022. Of the closed disputes, 15,895 were found ineligible for the IDR process. Common ineligibility reasons include incomplete submissions, challenges in determining whether the dispute is to state law or the federal IDR process, and incorrect batching.
[vii] Eligibility for the Federal IDR process depends on several factors, including jurisdiction (state vs. federal), proper batching and bundling, and adherence to applicable time periods.
[viii] A model disclosure notice regarding patient protections against surprise billing can be found here.