Implementing the No Surprises Act:  
Federal Regulation of Surprise Medical Billing

Updated: April 12, 2022

The federal regulation of certain surprise medical bills is effective as of Jan. 1, 2022. New protections regulate certain provider balance billing and create new pathways for patients to better understand the cost of services.

Learn more about the impact of the implementation of the No Surprises Act in the member-exclusive resource outlining key topics impacting group practices. For more information or questions, please contact MGMA Government Affairs at govaff@mgma.org.

Background

Surprise medical billing, or balance billing, results when patients receive care from out-of-network providers or facilities and the service costs are not fully covered by the patient’s insurance provider. The patient may then receive a medical bill that they were not expecting for services they may have believed were covered. As part of the Consolidated Appropriations Act, 2021 (CAA), Congress passed the No Surprises Act, which creates protections for patients by banning surprise medical bills under certain circumstances beginning January 1, 2022. There are two major components of the No Surprises Act:

- The federal regulation of certain surprise medical bills, and
- Patient transparency requirements.

The No Surprises Act establishes an independent dispute resolution (IDR) process for out-of-network care covered under the surprise billing protections. Providers and health plans may use an independent arbiter to determine final payment for certain out-of-network care. Notably, patients are held harmless for surprise medical bills that are protected under the new law.

The Departments of Health and Human Services (HHS), Labor, and Treasury (“The Departments”), are tasked with releasing regulations implementing the statutory ban on surprise billing. As of January 2022, the agencies have released three rules implementing the law:

- Requirements Related to Surprise Billing; Part I (Interim Final Rule, with Comment Period (IFC))
- Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enrollment (Proposed Rule (PR))
- Requirements Related to Surprise Billing; Part II (IFC)

Implementation Timeline

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The federal regulation of surprise medical bills prevents certain out-of-network (OON) providers from balance billing patients for services. The new requirements prioritize preventing patients from being caught in the middle of the provider and health plan dispute resolution process. Under the surprise billing law, certain OON providers are prohibited from balancing billing patients unless the provider is eligible to receive notice and consent exemptions from patients.

**Provider Types**

All OON providers at in-network facilities, as defined in statute, are prohibited from balancing billing patients. However, certain provider types are eligible to receive notice and consent from the patient to provide care and ultimately balance bill the patient.

Certain OON providers at in-network facilities may receive notice and consent to balance bill, except ancillary providers. **Ancillary providers** include emergency medicine, anesthesiology, pathology, radiology, laboratory and neonatology services provided by a physician or non-physician. Ancillary services also include items and services provided by assistant surgeons, hospitalists, and intensivists. As determined by law, HHS may specify other provider types that qualify as ancillary providers that are ineligible to receive notice and consent to balance bill patients.

### Who can balance bill patients under federal law?

1. **Emergency services**, as defined under the No Surprises Act, include pre-stabilization services that are provided after the patient is moved out of the emergency department and are subject to balance billing protections.
2. **In-network facilities** include hospitals, hospital outpatient departments, critical access hospitals, or ambulatory surgical centers that have a contractual relationship with a health plan or issuer.
3. **Ancillary services** include emergency medicine, anesthesiology, pathology, radiology, laboratory and neonatology services provided by a physician or non-physician. Ancillary services also include items and services provided by assistant surgeons, hospitalists, and intensivists.
4. **Available in-network providers** are considered “ancillary providers” for purposes of the law. If there is not an available in-network provider at the in-network facility able to furnish services, the out-of-network provider may not balance bill.
Notice and Consent

Non-ancillary OON providers at in-network facilities may balance bill patients for services if certain notice and consent requirements are met. These requirements ensure that patients are aware that the care provided is out-of-network, whether there are other health professionals within the facility that are in-network, and the estimated cost of care for services.

Providers opting to use the notice and consent process must meet specific timing and disclosure requirements. The notice and consent process may not be used in emergency situations by any provider, whether they are an ancillary provider or not.

The notice and consent process may not be used in any emergency situations by any provider, whether the provider is considered ancillary or not. The rules define emergency care to also include pre-stabilization services that are provided after the patient is moved out of the emergency department and are subject to balance billing protections.

Payment Dispute Resolution

Providers may not balance bill for services that are covered under the federal ban on surprise billing. For providers and health plans and issuers to determine the final payment for services, Congress established an independent dispute resolution (IDR) process.

The federal IDR process may be used to determine final payment for services covered under the federal ban on surprise billing when there is not an applicable state law or all-payer state model to determine the payment amount. See the section on state and federal laws for additional information.

Either party has up to 30 calendar days after the provider receives the initial payment for services or the notice of denial from the health plan. Once the IDR process is initiated, the provider and plan must first exhaust a 30-day negotiation period. If the parties fail to agree on a final payment, once this negotiation period ends, the formal IDR process may be initiated within 4 days, and once the formal IDR process is initiated, the two parties have 3 days to select an arbiter. Within 10 days of selection of the federal IDR entity, each party must submit their offers and any additional supplemental information to the IDR entity. Within 30 days of being selected to arbitrate the payment dispute, the IDR entity must issue the final determination of payment.

The selected IDR entity must be a federally certified arbiter and have no conflicts. The Departments have also established certain conflict of interest requirements and additional safeguards and protections. If the parties entering the dispute resolution process are unable to independently select and agree upon an arbiter, the Departments will identify and assign an IDR entity to the dispute resolution case.

Disclosure of Patient Protections Against Balance Billing

Provider and facilities are required to publicly post the applicable patient protections against balance billing in a central location within the facility and on the provider or facility’s public website (if applicable). This disclosure must be one-page (can be double sided) and must include any state balance billing protections and contact information for the appropriate state and federal agencies overseeing the balance billing protections.

Providers and facilities are also required to provide the disclosure to patients either in-person or by mail or email, as selected by the patient. The rules require that the disclosure be provided to patients no later than the date and time that payment is requested (including copays), and if no payment is requested, the disclosure must be provided no later than the date on which the provider or facility submits a claim to the patient’s insurer (86 Fed. Reg. 36914).
Federal Regulation of Surprise Medical Bills (Cont.)

Effective Jan. 1, 2022

What is the Qualifying Payment Amount (QPA)?

The qualifying payment amount, or “QPA,” is the health plan or issuer’s median contracted rate recognized by the plan on January 31, 2019, for the same or similar item or service in the same geographic region, adjusted for inflation. The median contracted rate is calculated based off all contracted rates by the health plan offered in the same insurance market. An insurance market is defined as either the individual market or small or large group market. The contracted rate is defined as the “total amount (including cost sharing) that a group health plan or health insurance issuer has contractually agreed to pay a participating provider.” Each contracted rate will be considered as a single data point when calculating the QPA.

Health plans and insurers are not required to provide specific information about QPA calculation but are required by the Departments to provide the QPA amount for a given item or service, a statement certifying that the QPA applies for purposes of determining patient cost sharing, and a statement with appropriate contact information about open negotiation and the availability of the federal IDR payment determination process.

Following a ruling in a federal court case, the QPA is no longer the assumed out-of-network rate for the federal IDR process. While the QPA may be one of the criteria used to determine the final payment amount, it is not used as the benchmark amount. HHS anticipates releasing additional rulemaking by May 2022.

IDR Payment Determination

Within 10 days of selecting the IDR entity, each party must submit an offer for a payment amount and any additional information to the IDR entity. Within 30 days of selection, the IDR entity must determine the final payment amount. In the payment determination process, the IDR entity may not consider any public payer rates, such as Medicare or Medicaid, when determining the appropriate payment amount. Once a payment determination is made, the IDR entity must provide a written rationale to both parties and the Departments.

Since a federal court determined that the QPA is no longer the assumed out-of-network rate for the federal IDR process, HHS will release additional rulemaking to provide additional guidance about how payment determinations will be made by the IDR entity.

IDR Process Fees

Once the federal IDR entity is selected, each participating party must pay the entire IDR entity processing fee, which will be held by the IDR entity in escrow until a determination is made, and a non-refundable administrative fee. Within 30 days of making the determination the IDR entity must refund the party whose offer was selected as the final payment amount. As the parties can continue negotiation once the IDR process has begun, if the parties independently negotiate a payment amount without the IDR entity, the parties will split the IDR entity fee.

The IDR process only applies to providers and services that are subject to the federal ban on surprise billing. If the IDR entity determines that the case does not qualify for the federal IDR process, the parties will be required to split the IDR processing fee.

For CY 2022, the Departments established the following fees for the IDR process:
- Administrative Fee: $50
- Allowable IDR entity fees: $200 - $500 (For single determinations)

The Departments will re-evaluate fees for future calendar years. Additional information is available here.

CMS has published a Frequently Asked Questions for Providers about the No Surprises Rules (April 6, 2022) providing additional clarity about the federal rules and patient protections.
Federal Patient Transparency Requirements

In addition to the federal regulation of surprise medical bills, the No Surprises Act creates several new patient transparency efforts to provide patients with the opportunity to better understand the cost of care, provider networks, and insurance plan cost sharing amounts.

Uninsured (or Self-Pay) Good Faith Estimates

Effective Jan. 1, 2022

Providers and facilities must provide uninsured patients or insured patients who do not plan on submitting claims and self-paying for services, or “self-pay patients” with a good faith estimate (GFE) of the total cost of expected care. The Departments intend for the GFE to provide patients with greater transparency about the cost of services and enable patients to compare prices across providers.

The GFE must reflect the cash price for services less any discounts and reflect the total cost of expected care furnished by the provider during a “period of care.” The Departments define a period of care as the day or multiple days in which the primary service is performed and other additional services that will likely be furnished in conjunction with the primary item or service.

Key Components of Uninsured GFE

The requirement to provide uninsured or self-pay patients with a GFE applies to all physicians or other healthcare providers "who [are] acting within the scope of practice of that provider's license or certification under applicable state law.” 86 Fed. Reg. 56014

The GFE must be provided to patients upon request or when a service is scheduled. When a service is scheduled more than 10 days in advance, the provider must provide the GFE within 3 business days. If the item or service is scheduled at least 3 business days in advance, the GFE must be provided within 1 business day.

The GFE must reflect the total cost of the period of care. The period of care includes the primary service, or the reason for the visit, and any foreseeable additional services that will be provided in conjunction with the primary service. In addition to the total estimated cost, the GFE must also include an itemized list and description of expected services, diagnosis codes*, services codes and associated anticipated charges.

An uninsured or self-pay patient may request a GFE for items or services. However, if the uninsured or self-pay patient schedules an item or service with the same provider, the provider must provide a new GFE upon scheduling.

*In an FAQ document, CMS clarified that a diagnosis code does not always need to be included on a GFE. A provider or facility is required to include a diagnosis code only where one is required for the calculation of the GFE.

What providers must furnish an uninsured (or self-pay) GFE?

All providers, regardless of clinical specialty and site of service, must comply with the uninsured or self-pay GFE requirements. There are no provider exceptions to these requirements.

Changes in Patient Insurance Status

If a patient schedules care with a provider, the provider must inquire whether or not the patient is insured as defined under the GFE requirements. If the patient is insured at the time of scheduling, but later the provider becomes aware that the patient is newly uninsured fewer than 3 business days in advance of the scheduled services, the provider is NOT required to provide a GFE or reschedule an appointment in order to provide a GFE.

However, if changes in insurance status that would make a patient eligible for a GFE are communicated more than 3 business days in advance, then a provider must provide the required GFE documentation to the patient under the appropriate timeframe.
Determining Uninsured or Self-Pay Patient Status
Patients that are uninsured or who have insurance but indicate that they are not intending to submit a claim to their insurer are considered “uninsured” or “self-pay” patients under the uninsured GFE requirements.

It is the responsibility of the convening provider who is furnishing the primary item or service to verify that the patient falls under the uninsured or self-pay definition by:

• Inquiring if an individual is enrolled in a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or Federal health care program, and
• Inquiring whether an individual who is enrolled in a group health plan, or group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan is seeking to have a claim submitted for the primary item or service with such plan or coverage (86 Fed. Reg. 56135)

An insured patient that determines they do not intend to submit a claim to their insurer can ultimately decide to submit a claim to their insurer for coverage. If an insured patient requests a GFE with the intent to self-pay for services and ultimately does submit a claim for coverage by their insurer, the patient is no longer eligible to enter the patient-provider dispute resolution process.

Timeline to Issue an Uninsured or Self-Pay GFE
Eligible patients may request a GFE from a provider, or upon scheduling a primary service, a provider must issue a GFE. If a patient makes an initial request for a GFE and ultimately schedules the service with the provider, the provider must issue a new GFE. Specific timing requirements are as follows:

• If an eligible patient requests a GFE, the provider has 3 business days to issue the GFE;
• If an eligible patient schedules care at least 10 business days in advance, the provider has 3 business days to issue the GFE;
• If an eligible patient schedules care at least 3 business days in advance, the provider has 1 business day to issue the GFE;
• If an eligible patient schedules care less than 3 business days out, then the provider is not required to issue an uninsured or self-pay GFE. (FAQs About Consolidated Appropriations Act, 2021 Implementation, Page 3)

Services Involving Multiple Providers and Facilities
The provider that initially schedules and furnishes the primary service is known as the “convening provider.” The Departments recognize that frequently, uninsured patients will receive care from multiple providers during one period of care, these auxiliary providers are known as “co-providers.” The Departments require the convening provider to coordinate with co-providers and include these estimated costs on the GFE for uninsured patients.

The Departments are providing flexibility for convening providers in CY 2022; convening providers will not be required to obtain GFEs from co-providers. Instead, the Departments encourage convening providers to provide a range of potential costs of services furnished by co-providers if they are unable to receive specific cost estimates.

Patient and Provider Dispute Resolution Process
The No Surprises Act establishes protections for uninsured or self-pay patients from unforeseeable medical costs. The law permits that patients may initiate a patient-provider dispute resolution process when the total billed charges for a provider or facility exceeds the estimate on the GFE provided to the patient by a “substantial amount.” The Departments defined a “substantial amount” as $400 more than the provided GFE.

The $400 threshold for initiating the patient-provider dispute resolution process is based on the difference in total charges by a provider or facility, regardless if the services were included in the GFE or not.
Federal Patient Transparency Requirements (Cont.)

Insured Good Faith Estimates and Advanced Explanation of Benefits

Enforcement Delayed, Not Yet Effective

The No Surprises Act also requires that health plans or issuers provide patients with an advanced explanation of benefits (AEOB) upon receiving a “good faith estimate” for the cost of services from a provider. The AEOB must include:

1. The network status of the provider or facility,
2. The contracted rate for the item or service,
3. The good faith estimate received from the provider,
4. A good faith estimate of the anticipated cost-sharing that the patient will be responsible for and the estimated amount the health plan or issuer will cover, and
5. A disclaimer that coverage is subject to potential care management processes.

The Departments issued a notice stating they will not be enforcing the AEOB requirements on January 1, 2022. The Departments are delaying the implementation of these provisions until the Departments and stakeholders can appropriately develop and implement the technical infrastructure necessary to carry-out these requirements.

The AEOB will be based off a good faith estimate that is produced by the provider furnishing the item or service. Additional information about the requirements related to the good faith estimate and the AEOB will be made available during the rulemaking process in CY 2022.

Additional Patient Transparency Provisions

Provider Directory Information

Health plans and issuers are required to provide updated provider directories to patients to help inform patients on the network status of clinicians. If a patient receives care from an out-of-network clinician that based on outdated information in a provider directory, the plan cannot impose cost sharing that is greater than what it would have been if the provider been in-network.

The Departments do not intend to issue rulemaking prior to the statutory effective date of January 1, 2022. The Departments will issue notice and comment rulemaking in CY 2022. Until the effective date of such rulemaking, the Departments determine that plans will not be out-of-compliance if they do not charge patients more than the in-network cost-sharing amount that would have applied.

Continuity of Care

The No Surprises Act also provides certain patient protections when there are changes in network status of a patient’s healthcare providers. If a contractual relationship between a health plan or issuer and a provider or facility is terminated, the health plan must notify each enrollee that is a continuing care patient that a provider they were receiving care from has been removed from the patient’s network and that the patient has a right to transitional care. The patient may have up to 90-days of transitional care during the plan will provide continued benefits and applicable cost-sharing.

The Departments are using enforcement discretion for such continuity of care protections for patients in CY 2022. The Departments will undertake notice and comment rulemaking to fully implement these protections, and until such time, providers, facilities, and health plans and issuers are expected to implement the continuity of care requirements using a good faith interpretation of the statute.

Additional information about the patient transparency provisions as part of the No Surprises Act can be found here.
State and Federal Surprise Billing Laws

Prior to the passage of the No Surprises Act, the federal law regulating, in some instance and to some degree, balance billing, many states had implemented different state-wide requirements related to the practice of balance billing. As the federal government continued to craft the nation-wide patient protections, Congress established that a “Specified State Law” will preempt federal in states where they were enacted in two key areas:

1. In determining the out-of-network payment rate and dispute resolution process, and
2. How the recognized amount is calculated to determine patient cost sharing amounts.

The federal regulations implementing the No Surprises Act further outline the interplay between the state and federal protections against surprise medical bills. While the above instances are direct deferral to state law, the Departments generally also defer to state law in instances where the state protections against surprise bills are more protective than the federal No Surprises Act.

Examples of a more protective state law:
- A state law prohibits a greater number of services from balance billing.
- A state requires greater disclosure of information during notice and consent process.


Example 1. Facts. A health insurance issuer licensed in State A covers a specific non-emergency service that is provided to an enrollee by a nonparticipating provider in a participating health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by nonparticipating providers in a participating health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided. **Conclusion.** In this Example 1, State A’s law would apply to determine the recognized amount and the out-of-network rate.

Example 2. Facts. Same facts as Example 1, except that the nonparticipating provider and participating health care facility are located and licensed in State B. State A’s law does not apply to the provider, because the provider is licensed and located in State B. **Conclusion.** In this Example 2, State A’s law would not apply to determine the recognized amount and out-of-network rate. Instead, the lesser of the billed amount or QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer, or an amount determined by an IDR entity would apply to determine the out-of-network rate.

Exceptions for Self-Funded Health Plans

The No Surprises Act did not reverse ERISA policy, and as such, self-funded plans are not generally subject to state regulation. The Departments recognize that under ERISA, the federal requirements related to balance billing would generally apply to all self-funded plans. However, the Departments create an exception in states where self-funded plans can opt-in and comply with state processes. In states with these exceptions, self-funded plans can voluntarily opt in to state law that provides for a method for determining the cost-sharing amount to total amount payable under such plans to comply with requirements related to surprise billing.
Key Considerations for Group Practices

There are many moving parts before the effect ban on surprise medical billing and the implementation date for many new patient transparency requirements of January 1, 2022. Medical practices should fully understand what requirements apply to the clinicians in their practice and what administrative and clinical practice changes must be made in order to comply with the new requirements.

Determine whether the federal ban on surprise medical billing applies to your group practice or physicians within your group

If the ban on surprise medical billing applies, determine whether clinicians are eligible to participate in the Notice and Consent process to balance bill patients

Evaluate current requirements for patient transparency and good faith estimates and determine what current workflows and data platforms must be adjusted to meet the new requirements

Consult internally to determine whether your state has an applicable state law in place

For more information, please visit the Center for Medicare & Medicaid Services No Surprises webpage or Contact MGMA Government Affairs at govaff@mgma.org