CMS No Surprise Act – January 1, 2022

Rules focused on specific protections and provisions

On July 1, 2021, the "Requirements Related to Surprise Billing; Part I," an interim final rule was issued to restrict surprise billing for patients in job-based and individual health plans who get emergency care, non-emergency care from out-of-network providers at in-network facilities, and air ambulance services from out-of-network providers.

On September 30, 2021, a second final rule was issued and was open for public comment. The "Requirements Related to Surprise Billing; Part II" rule provides additional protections against surprise medical bills, including:

- Establishing an independent dispute resolution process to determine out-of-network payment amounts between providers (including air ambulance providers) or facilities and health plans.
- Requiring good faith estimates of medical items or services for uninsured (or self-paying) individuals.
- Establishing a patient-provider dispute resolution process for uninsured (or self-paying) individuals to determine payment amounts due to a provider or facility under certain circumstances.
- Providing a way to appeal certain health plan decisions.

Together, these provide the groundwork to provide consumers with protection against surprise billing.

On November 17, 2021, a third final rule was issued and was open for public comment. The "Prescription Drug and Health Care Spending" rule implements new requirements for group health plans and issuers to submit certain information about prescription drug and health care spending. This includes, among other things, information on the most frequently dispensed and costliest drugs, and enrollment and premium information, including average monthly premiums paid by employees versus employers.

How do these rules affect providers, facilities, and air ambulance providers?

Like health plans, the rules lay out the independent dispute resolution process that providers, facilities, and air ambulance providers can follow in the case of certain out-of-network claims when open negotiations don't result in an agreed-upon payment amount. Providers, facilities, and air ambulance providers will be required to meet deadlines, attest to no conflicts of interest, choose a certified independent dispute resolution entity, submit a payment offer and provide additional information if needed. This could include information like level of training, experience, and severity of condition.

Providers, facilities, and air ambulance providers are also required to give uninsured (or self-pay) individuals good faith estimates of expected charges for scheduled health care services and may have to participate in a patient – provider payment dispute resolution process if their billed charges are higher than the good-faith estimates.

Background and Purpose

These requirements generally apply to items and services provided to individuals enrolled in group health plans or group or individual health insurance coverage, and Federal Employees Health Benefit plans. The good faith estimate requirement and the requirements related to the patient-provider dispute resolution process (PPDR) also apply to the uninsured.

The PPDR process is set up for:

- People without health insurance.
- People with health insurance who receive an item or service that isn't covered by their plan or coverage.
- People with health insurance who plan to not use their plan or coverage to pay for a portion or all the costs for the item or service.

People with health insurance includes those with:

- A group health plan (a plan through their employer or union),
- Group or individual health insurance coverage offered by a health insurance issuer,
- A Federal health care program (such as Medicaid, Medicare or TRICARE), or
- A health benefits plan under a Federal Employees Health Benefits (FEHB) Program.

Note: These requirements do not apply to beneficiaries or enrollees in federal programs such as Medicare, Medicaid, HIS, Veterans Affairs Health Care, or Tricare.

Provider and facility requirements that apply starting January 1, 2022

1. No balance billing for out-of-network emergency services (PHSA 27999B-1; 45 CFR 149.410)
2. No balance billing for non-emergency services by nonparticipating providers at certain participating health care facilities, unless notice and consent was given in some circumstances (PHSA 2799B-2; 45 CFR 149.420)
3. Disclose patient protections against balance billing (PHSA 2799B-3; 45CFR 149.430) This information should be posted prominently at the location of the facility, post it on a public website (if applicable) and provide it to the participant, beneficiary or enrollee in a timeframe and manner outlined in the regulation.
4. No balance billing for air ambulance services by nonparticipating air ambulance providers (PHSA 2799B-5; 45 CFR 149.440)
5. Provide good-faith estimate in advance of scheduled services, or upon request (PHSA 2799B-6; 45 CFR 149.610 (for uninsured or self-pay individuals). The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided in conjunction with the primary item or service, including items or services that may be provided by other providers and facilities. If the uninsured (or self-pay) individual is billed for an amount at least $400 above the estimate, the individual may be eligible to start a Patient-Provider Dispute Resolution (PPDR) process by submitting a request to HHS and paying a small administrative fee. The PPDR process is handled by a third-party company certified by the Department of Health and Human Services (HHS). This company will decide if the estimated amount, or billed amount, or another amount in between the estimated amount and billed amount should be paid.
6. Ensure continuity of care when a provider's network status changes (PHSA 2799B-8)

7. Improve provider directories and reimburse enrollees for errors (PHSA 2799B-9)

Good faith estimates for uninsured or self-pay patients

Under the No Surprises Act, uninsured patients and commercially insured patients who choose not to use their benefits are entitled to a good faith estimate (GFE) of charges from providers before scheduled services. The GFE must be provided within one business day of a service being scheduled or a GFE requested. If the actual charges by a particular provider or facility exceed the GFE amount by more than $400, the patient is entitled to dispute the charges under an arbitration process. Physicians' responsibilities for the GFE differ depending on whether they serve as a "convening provider" or a "co-healthcare provider." A **convening health care provider** (or facility) is one that receives an initial request for a GFE or that is responsible for scheduling the primary service. A **cohealth care provider** (or facility) is one, other than the convening provider or facility, that furnishes items or services in conjunction with the primary service. The Act also requires that GFEs be available for insured patients, but that requirement is not being enforced until the government resolves further issues regarding its implementation.

What triggers the obligation to provide a GFE?

A patient may request a GFE prior to scheduled care. Convening providers are required to treat any discussion with or inquiry from an uninsured patient regarding costs to be a request for a GFE. The convening provider or facility may provide a single GFE for recurring services, as long as the GFE is updated at least every 12 months. The GFE must be provided either in writing or electronically, as requested by the patient.

Convening provider responsibilities

TO WHICH PATIENTS MUST A GFE BE PROVIDED? A convening provider or facility is required to inquire whether a patient is covered under commercial health coverage, Medicare, Medicaid, or the Federal Employees Health Benefits Program (FEHBP) and, if the patient is covered under commercial coverage or FEHBP, whether he or she intends to use that coverage. An individual covered only by short-term limited-duration insurance is considered uninsured for this purpose and is entitled to receive a GFE.

The convening provider or facility is then required to inform uninsured and self-pay patients of the availability of the GFE. Notice of the availability of the GFE must be posted on the provider's or facility's website, at the office, and onsite where scheduling or cost questions arise. The notice must be clear, understandable, prominently displayed and easily searchable.

The current version of HHS's model notice is available here: https://www.cms.gov/regulationsand-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10791.

Note: In 2022, the good faith estimate may not include all expected charges for items and services from a co-provider or co-facility for items and services that are usually expected to be provided along with the primary item(s) or service(s). This means, for example, that until January 1, 2023, if you schedule a knee replacement surgery with a particular surgeon, your 4 surgeon's good faith estimate may not include the

expected charges from your anesthesiologist. You may however request a good faith estimate directly from a co-provider or co-facility.

Read more at

No Surprises Act | CMS.

High level overview of No Surprises Act provider requirements (cms.gov).

HHS PPDR Individuals Guidance (cms.gov).

Implementation of the No Surprises Act | American Medical Association (ama-assn.org).

AMA toolkit for physicians: Preparing for implementation of the No Surprises Act (ama-assn.org)