

Five Takeaways from New Requirements under the *No Surprises Act* Effective January 1, 2022

Overview

The *No Surprises Act* was enacted as part of the *Consolidated Appropriations Act, 2021*, on December 27, 2020 to expand patient protections related to emergency services, particularly related to surprise bills and excessive patient cost-sharing stemming from insurance plan policies related to care delivered by providers or facilities that are “out-of-network.” Federal agencies have issued several regulations to implement the provisions of the *No Surprises Act*, with most provisions taking effect beginning January 1, 2022. While the regulations contain numerous requirements and specific details on how the requirements will apply, this document aims to highlight five takeaways that may be of interest to any practice, regardless of whether practitioners typically provide services in emergency departments.

Takeaway 1: Patient Protections Apply to More than Just Emergency Services

The *No Surprises Act* prohibits balance billing and excessive cost-sharing above in-network cost-sharing requirements in certain scenarios, including emergency services. However, these protections extend beyond those services that are typically considered emergency services to include ***certain post-stabilization services***. Further, the balance billing and cost-sharing protections also apply to ***non-emergency care furnished by out-of-network providers furnishing services at in-network facilities***¹ – for example if a non-participating provider is conducting a scheduled elective procedure at a hospital that is in the provider network of the patient’s health insurance coverage.

For the applicable post-stabilization services, as well as services furnished by out-of-network providers at in-network facilities, the balance billing protections can be waived, but only if (1) the provider adheres to specified notice protocols and (2) the patient consents to receive and be balance billed for the services despite the provider being out of network. Requirements for these protocols include, but are not limited to:

- The use of standard notice and consent documents
- The delivery of the documents within specified timeframes ahead of the service (at least 72 hours in advance, or if scheduled within 72 hours, no later than 3 hours before the service is furnished)
- The provision of a good faith estimate (GFE) for the items and services involved. For a non-participating provider, the GFE need only address the charges to be submitted by that provider.

Restrictions apply regarding when balance billing protections can be waived. For example, they cannot be

¹ Under interim final rulemaking, a “facility” for the purposes of the patient balance billing and cost sharing protections is defined as a hospital, a hospital outpatient department, a critical access hospital, or an ambulatory surgical center.

waived for emergency, unforeseen, or urgent services, or for “ancillary services” or assistants-at-surgery, among other services.

Takeaway 2: Billing and Cost-Sharing Protections are Largely Tied to a Qualifying Payment Amount (QPA)

The *No Surprises Act* created the concept of a Qualifying Payment Amount, or QPA. The QPA is an amount that, based on interim final rulemaking, generally is intended to represent the median of the contracted rates of the plan or issuer for the item or service in the geographic region. It is established by a plan or issuer based on rates in effect on January 31, 2019, and it is increased by inflation for each year thereafter.

Except in certain cases, the amount of the patient’s allowed cost-sharing in the protected scenarios discussed above will be based on the QPA. For instance, if a patient’s in-network co-insurance was 20% of the allowed amount when provided in network, for an out-of-network item or service covered by these provisions, the patient’s cost-sharing limit would generally be 20% of the QPA, and collection of amounts above the cost-sharing limit would be prohibited.

The second manner in which the QPA becomes relevant is for payment disputes that are eligible for the federal independent dispute resolution (IDR) process. More details regarding the Federal IDR process are discussed in the next section. (As noted below, however, the Federal IDR process will not always apply.) The QPA plays a role in Federal IDR in that the arbiter must consider the QPA as part of the deliberation in making a final payment determination. Under interim final rulemaking, IDR entities “must presume that the QPA is an appropriate payment amount.” However, this requirement for the federal IDR process is opposed by stakeholders and has been challenged in legal proceedings.

Takeaway 3: An Independent Dispute Resolution Process May Be Available to Address Disputed Payment Amounts between Non-Contracted Providers and Payers²

The *No Surprises Act* generally defers to state law and regulations on balance billing and out-of-network payments from plans to providers. To the extent that there is an applicable state law that applies to item or service involved in a potential dispute (including with respect to the insurance coverage and the non-participating provider), then the dispute must be addressed in accordance with the state law. This may or may not involve a state-based dispute resolution process.

However, if no state law applies, then the federal government has established a federal IDR process.³ The Centers for Medicare and Medicaid Services (CMS) has created a “[Federal IDR Portal](#)” to facilitate the federal IDR process and submission of information. A number of rules apply regarding steps that must be taken before an IDR request is initiated, to advance the IDR process (including the submission by each party

² Note that this discussion is focused on disputes regarding payment amounts, not coverage determinations. The *No Surprises Act* is generally designed to address issues of payment rather than coverage.

³ CMS has been issuing letters to states that provide additional information on the extent to which federal IDR processes would be available for providers in each state. The letters can be found on the CMS website at <https://www.cms.gov/CCIIO/Programs-and-Initiatives/Other-Insurance-Protections/CAA>.

to the dispute of an offer), to receive a payment determination, and to reconcile payment discrepancies in accordance with the payment determination. Additionally, requests for dispute resolution are subject to fees collected by IDR entities.⁴ Notably, nothing regarding the IDR process affects the patient’s cost-sharing liability.

Takeaway 4: Any Provider Potentially Furnishing Care to an Uninsured or Self-Pay Patient May Be Required to Furnish a Good Faith Estimate of Expected Costs

Separate from the patient protections that apply to emergency services and specified out-of-network services discussed under Takeaway 1, which only apply to providers in the circumstances noted therein, ***all*** providers have obligations under the *No Surprises Act* and its implementing regulations to provide a Good Faith Estimate (GFE) to patients who are either uninsured or who may not seek to submit a claim to their health insurance issuers for an item or service (i.e. a “self-pay” individual). Under federal regulations, a GFE is a “notification of expected charges for a ***scheduled*** or ***requested*** [emphasis added] item or service, including items or services that are reasonably expected to be provided in conjunction with such scheduled or requested item or service” by applicable providers.⁵ The provision of the GFE places significant requirements on a primary – or “convening” – provider (who receives the initial request for the GFE and who is or would be, under a request, responsible for scheduling the primary item or service) to coordinate collection of expected charge information from other providers who would customarily provide services in conjunction with the primary item or service. Strict timelines apply for the provision of the good faith estimate (e.g., no later than 3 business days after scheduling, or in some cases, as soon as 1 business day after scheduling if a service is scheduled within 3 – 10 business days of furnishing the item or service).⁶ Additional requirements (e.g. related to informing the public of the availability of a GFE; the content and format of the GFE; requirements for co-providers; record retention; and more) also apply.

If the total of the billed charge is more than \$400 higher than the GFE, the patient may initiate a patient-provider dispute resolution (PPDR) process, which then triggers additional action by the provider. However, these provisions also are designed to defer to state laws that govern billing disputes between uninsured or self-pay individuals and providers.

CMS has posted [letters by state](#) regarding how enforcement of *No Surprises Act* requirements and implementation of IDR and patient-provider dispute resolution processes will take place at the federal or state level. CMS has also prepared [Frequently Asked Questions](#) to address the GFE requirements for uninsured and self-pay patients.

Takeaway 5: Rulemaking Continues

Federal agencies finalized many of their requirements for the *No Surprises Act* through interim final rulemaking, so while many provisions take effect January 1, 2022, there is the potential for policies to change as they are finalized. However, the timeline for final policies to be issued is unclear, and policies

⁴ IDR entity fees may range from \$200 to \$500 for a single determination and from \$268 to \$670 for batched determinations, where batched submissions must meet specified criteria to be submitted together.

⁵ 86 FR 55980

⁶ Note that a GFE is not required to be provided if an item or service is scheduled in less than 3 business days.

may remain in place for some time. Moreover, many additional provisions required by the *No Surprises Act* have not yet been addressed through rulemaking, so further requirements are expected to be promulgated in the future.

Finally, CMS has yet to address a number of key implementation and operational questions raised by stakeholders: for example, whether on- and off-campus provider-based departments are considered a “facility,” presumably as a “hospital outpatient department,” and therefore required to meet the provider obligations established under the rules that seek to protect patients from surprise bills for non-emergency services furnished by nonparticipating providers at participating health care facilities (per Takeaway 1).

Additional Resources

More information on the *No Surprises Act* and regulations issued to date can be found on the [CMS No Surprises Act website](#), including but not limited to:

- [Information on rules promulgated to date and related fact sheets](#)
- [Provider resources](#)
- [Additional information on patient protections](#)
- [A list of approved federal IDR entities](#)

Additionally, the Consumer Financial Protection Bureau has posted a [bulletin](#) regarding disallowance of debt collection practices in excess of *No Surprises Act* cost-sharing limits.