Fact sheet

Requirements Related to Surprise Billing; Part II Interim Final Rule with Comment Period

Sep 30, 2021 Billing & payments

On September 30, 2021, the Department of Health and Human Services (HHS), the Department of Labor, and the Department of the Treasury (collectively, the Departments), along with the Office of Personnel Management (OPM), released an interim final rule with comment period, entitled "Requirements Related to Surprise Billing; Part II." This rule is related to Title I (the No Surprises Act) of Division BB of the Consolidated Appropriations Act, 2021, and establishes new protections from surprise billing and excessive cost sharing for consumers receiving health care items/services. It implements additional protections against surprise medical bills under the No Surprises Act, including provisions related to the independent dispute resolution process, good faith estimates for uninsured (or self-pay) individuals, the patient-provider dispute resolution process, and expanded rights to external review.

In conjunction with the release of this interim final rule, the Departments and OPM launched a website focused primarily on providing general information about No Surprises Act provisions. It will include a federal portal for organizations to apply to become certified independent dispute resolution entities and for providers and payers to participate in the federal independent dispute resolution process. The Departments and OPM intend to post additional information over the next several months, including information about how to initiate an independent dispute resolution process in the federal portal, and plan to highlight different provisions as they become more relevant to different stakeholders and audiences.

Background – Surprise Billing and the Need for Greater Protections

Most group health plans and health insurance issuers that offer group or individual health insurance coverage have a network of providers and health care facilities (in-network providers) that agree to accept a specific payment amount for their services. Providers and

facilities that are not part of a plan or issuer network (out-of-network or "OON" providers)

usually charge higher amounts than the contracted rates the plans or issuers pay to in-network providers.

When a person with health coverage gets care from an OON provider, their health plan or issuer usually does not cover the entire OON cost, leaving the person with higher costs than if they had been seen by an in-network provider. In many cases, the OON provider may bill the individual for the difference between the charge and the amount paid by their plan or insurance, unless prohibited by state law. This is known as "balance billing."

A "balance bill" may come as a surprise for many people. A surprise bill is an unexpected bill from a health care provider or facility. This can happen when a person with health insurance unknowingly gets medical care from a provider, facility, or provider of air ambulance services outside their health plan's network. Surprise billing happens in both emergency and non-emergency care settings.

In an emergency, an individual usually gets care at the nearest emergency department. Even if they go to an in-network hospital for emergency care, they might get care from OON providers at that facility. For non-emergency care, an individual might choose an in-network facility or an in-network provider, but not know that a provider involved in their care (for example, an anesthesiologist or radiologist) is an OON provider. In some of these instances, a person can receive a surprise bill from an OON provider that is higher than the amount they would otherwise pay or had planned for their in-network care. The No Surprises Act protects these individuals from large and unexpected surprise bills.

When individuals do not have an opportunity to select in-network providers or are given care by an OON provider involved in their in-network care, their health care costs go up overall. Surprise billing is often used as leverage by providers to get higher in-network payments, which result in higher premiums, higher cost sharing for consumers, and increased health care spending overall.[1] Studies have shown that surprise bills can be expensive for the patient, their employer, and the health care system.

- A recent study found that payments made to providers/facilities by people who got a surprise bill for emergency care were more than ten times higher than those made by other individuals for the same care.[2]
- OON cost sharing and surprise bills usually do not count toward a person's deductible and maximum out-of-pocket limit. Individuals with surprise bills may have to spend more out-of-pocket because they have to pay their OON cost sharing and surprise billing amounts regardless of whether they've met their deductible and maximum out-of-pocket limits.
- Studies have shown that in the period from 2010-2016, more than 39% of emergency

department visits to in-network hospitals resulted in surprise bills, increasing to 42.8% in 2016. During the same period, the average amount of a surprise medical bill also increased from $220 to $628.[3]

- Although some states have enacted laws to reduce or eliminate balance billing, these efforts do not provide comprehensive consumer protections.[4] Even in a state that has enacted protections, they typically do not apply to individuals enrolled in self-insured health coverage, as federal law generally preempts state laws that regulate self-insured group health plans sponsored by private employers. In addition, states have limited power to address surprise bills that involve an out-of-state provider and providers of air ambulance services.
- The No Surprises Act supplements state balance billing laws and All-Payer Model Agreements. In cases where a state has an All-Payer Model Agreement or where a state law applies, the state law or All-Payer Model Agreement generally determines an individual's cost-sharing amount and the OON payment rate.

In addition to protecting consumers, the balance billing provisions in the No Surprises Act have the potential to decrease health care spending, despite administrative burdens. When the rules become effective, they will provide patients immediate protection against balance bills, reducing their exposure to out-of-pocket medical expenses. The Congressional Budget Office has projected that the No Surprises Act will reduce private health plan premiums by 0.5%-1% on average, and reduce the federal deficit by $17 billion over 10 years.[5]

Prior Rulemaking

On July 13, 2021, the Departments and OPM issued "Requirements Related to Surprise Billing; Part I,"[6] a rule that will restrict excessive out-of-pocket costs to consumers resulting from surprise billing and balance billing. This rule goes into effect for health care providers and facilities, and providers of air ambulance services on January 1, 2022, and for plan, policy, or contract years starting on or after January 1, 2022, for group health plans, health insurance issuers, and Federal Employees Health Benefits (FEHB) program carriers. The rule:

- Bans balance billing for emergency services. Cost-sharing for emergency services must be determined on an in-network basis.
- Requires that patient cost-sharing, such as copayments, co-insurance, or a deductible, for emergency services and certain non-emergency services provided at an in-network facility cannot be higher than if such services were provided by an in-network provider, and any cost-sharing obligation must be based on in-network provider rates.
- Prohibits OON charges for items or services provided by an OON provider at an in-network facility, unless certain notice and consent is given. Providers and facilities must provide patients with a plain-language consumer notice explaining that patient consent

is required to receive care on an OON basis before that provider can bill the patient more than in-network cost-sharing rates.

To protect patients from surprise bills and remove them from payment disputes between providers, facilities, or providers of air ambulance services and plans or issuers, the July 13, 2021 rule established that, for emergency services and certain non-emergency services furnished by OON providers at certain in-network facilities, the patient pays a cost-sharing rate similar to that imposed in-network. The rate for this cost sharing is calculated based on a state All-Payer Model Agreement, specified state law, or, if neither of these apply, the qualifying payment amount (QPA). The QPA is generally the plan or issuer's median contracted rate for the same or similar service in the specific geographic area. The balance of the bill to be paid by the plan or issuer following patient cost sharing and any initial payment from the plan or issuer is determined between the provider, facility, provider of air ambulance services, and the plan or issuer through an open negotiation period and, if the parties cannot agree on a payment amount, the federal independent dispute resolution process described below.

Review the Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period fact sheet for more information on this earlier rule.

On September 10, 2021, the Departments and OPM released a notice of proposed rulemaking (NPRM) to implement certain provisions of the No Surprises Act, entitled "Reporting Requirements Regarding Air Ambulance Services, Agent and Broker Disclosure Requirements and HHS Enforcement." If finalized, this proposed rule would establish:

- New reporting requirements regarding air ambulance services;
- New disclosures and reporting requirements regarding agent and broker compensation;
- New procedures for enforcement of Public Health Service Act (PHS Act) provisions against providers, health care facilities, and providers of air ambulance services;
- New disclosure and reporting requirements applicable to issuers of individual health insurance coverage and short-term, limited-duration insurance regarding agent and broker compensation; and
- Revisions to existing PHS Act enforcement procedures for plans and issuers.

Review the Air Ambulance NPRM – Fact Sheet for more information.

Summary of the September 30, 2021 Rule

The "Requirements Related to Surprise Billing; Part II" rule builds on the July 1, 2021 rule

and the September 10, 2021 NPRM to continue implementing the No Surprises Act. The rule issued on September 30, 2021, outlines the federal independent dispute resolution process, good faith estimate requirements for uninsured (or self-pay) individuals, patient-provider dispute resolution processes for uninsured (or self-pay) individuals, and external review provisions of the No Surprises Act.

Independent Dispute Resolution

The September 30, 2021 rule establishes the federal independent dispute resolution process that OON providers, facilities, providers of air ambulance services, plans, and issuers in the group and individual markets may use to determine the OON rate for applicable items or services after an unsuccessful open negotiation. Not all items and services are eligible for the federal independent dispute resolution process. This process applies only to those services for which balance billing was prohibited under the "Requirements Related to Surprise Billing; Part I" rule.

Before initiating the federal independent dispute resolution process, disputing parties must initiate a 30-day "open negotiation" period to determine a payment rate. In the case of a failed open negotiation period, either party may initiate the federal independent dispute resolution process. The parties then may jointly select a certified independent dispute resolution entity to resolve the dispute. The certified independent dispute resolution entity and personnel of the entity assigned to the case must attest that they have no conflicts of interest with either party. If the parties cannot jointly select a certified independent dispute resolution entity or if the selected certified independent dispute resolution entity has a conflict of interest, the Departments will select a certified independent dispute resolution entity. After a certified independent dispute resolution entity is selected, the parties will submit their offers for payment along with supporting documentation. The certified independent dispute resolution entity will then issue a binding determination selecting one of the parties' offers as the OON payment amount. Both parties must pay an administrative fee ($50 each for 2022), and the non-prevailing party is responsible for the certified independent dispute resolution entity fee for the use of this process. To learn more about the 2022 administrative fee and allowable independent dispute resolution entity fee ranges for 2022, see Calendar Year 2022 Fee Guidance for the Federal Independent Dispute Resolution Process Under the No Surprises Act. Details on important open negotiation and independent dispute resolution deadlines can be found in the table below.

When making a payment determination, certified independent dispute resolution entities must begin with the presumption that the QPA is the appropriate OON amount. If a party submits additional information that is allowed under the statute, then the certified independent dispute resolution entity must consider this information if it is credible. For the independent dispute resolution entity to deviate from the offer closest to the QPA, any

information submitted must clearly demonstrate that the value of the item or service is materially different from the QPA.

The rule also describes the independent dispute resolution entity certification process and the information independent dispute resolution entities must submit to be certified as federal independent dispute resolution entities. The rule provides a process by which members of the public, including providers, facilities, providers of air ambulance services, and plans or issuers, can petition for the denial or revocation of certification of an independent dispute resolution entity.

To ensure transparency in the independent dispute resolution process, the rule establishes monthly reporting requirements for certified independent dispute resolution entities to inform quarterly public reports on payment determinations.

The Departments will certify independent dispute resolution entities on a rolling basis. Entities that would like to be certified by January 1, 2022, should submit their application by November 1, 2021.

Learn more about the independent dispute resolution entity certification process or apply to be a certified independent dispute resolution entity at the federal portal.

To stay up to date with the federal independent dispute resolution process, sign up or access your subscriber preferences at the No Surprises Act Dispute Resolution" email list.

Important Open Negotiation and Independent Dispute Resolution Deadlines

Independent Dispute Resolution Action	Timeline
Initiate 30-business-day open negotiation period	30 business days, starting on the day of initial payment or notice of denial of payment
Initiate independent dispute resolution process following failed open negotiation	4 business days, starting the business day after the open negotiation period ends
Mutual agreement on certified independent dispute resolution entity selection	3 business days after the independent dispute resolution

	initiation date
Departments select certified independent dispute resolution entity in the case of no conflict-free selection by parties	6 business days after the independent dispute resolution initiation date
Submit payment offers and additional information to certified independent dispute resolution entity	10 business days after the date of certified independent dispute resolution entity selection
Payment determination made	30 business days after the date of certified independent dispute resolution entity selection
Payment submitted to the applicable party	30 business days after the payment determination

Good Faith Estimates for Uninsured (or Self-pay) Individuals – Requirements for Providers and Facilities

When scheduling an item or service, or if requested by an individual, providers and facilities are required to inquire about the individual's health insurance status or whether an individual is seeking to have a claim submitted to their health insurance coverage for the care they are seeking. The provider or facility must provide a good faith estimate of expected charges for items and services to an uninsured (or self-pay) individual, meaning an individual that:

- Does not have benefits for an item or service under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, federal health care program (as defined in section 1128B(f) of the Social Security Act), or a health benefits plan under chapter 89 of title 5, United States Code[7],[8]; or
- Has benefits for such items/services under a group health plan, group or individual health insurance coverage offered by a health insurance issuer, or a health benefits plan under chapter 89 of title 5, United States Code, but does not seek to have a claim submitted to their plan, issuer, or carrier for the item or service.

The good faith estimate must include expected charges for the items or services that are reasonably expected to be provided together with the primary item or service, including items or services that may be provided by other providers and facilities. For example, for a surgery, the good faith estimate might include the cost of the surgery, any labs or tests, and

surgery, the good faith estimate might include the cost of the surgery, any labs or tests, and the anesthesia that might be used during the operation. If an item or service is something that isn't scheduled separately from the surgery itself, it will generally be included in the good faith estimate. Other items or services related to the surgery that might be scheduled separately, like pre-surgery appointments or physical therapy in the weeks after the surgery, won't be included in the good faith estimate.

HHS understands that it may take time for providers and facilities to develop systems and processes for providing and receiving the required information from others. Therefore, for good faith estimates provided to uninsured (or self-pay) individuals from January 1, 2022, through December 31, 2022, HHS will exercise its enforcement discretion in situations where a good faith estimate provided to an uninsured (or self-pay) individual does not include expected charges from other providers and facilities that are involved in the individual's care.

Patient-Provider Dispute Resolution

In a situation where an uninsured (or self-pay) individual receives a good faith estimate and then is billed for an amount substantially in excess of the good faith estimate, HHS establishes in the September 30, 2021 rule a patient-provider dispute resolution process to determine a payment amount. The September 30, 2021 rule provides eligibility details for this dispute resolution process, a definition of "substantially in excess," and further information on the selection process for select dispute resolution (SDR) entities that will resolve disputes through the patient-provider dispute resolution process.

A patient's bill will be determined eligible for the patient-provider dispute resolution process if the patient received a good faith estimate, if the process is initiated within 120 calendar days of the patient receiving the bill, and if the bill is substantially in excess of the good faith estimate. HHS has defined "substantially in excess" as the billed charges being at least $400 more than the good faith estimate for any provider or facility listed on the good faith estimate.

SDR entities will make payment determinations as part of the patient-provider dispute resolution process. The patient-provider dispute resolution process has timelines for documentation submission and payment determination, and participating individuals will be charged an administrative fee. To ensure the administrative fee does not act as a barrier for consumers accessing dispute resolution, the fee will be set at $25 in the first year and will be updated through sub-regulatory guidance in future years.

External Review

The September 30, 2021 rule amends final rules issued by the Departments in 2015 related to external review. The September 30, 2021 rule expands the scope of adverse benefit

to external review. The September 30, 2021 rule expands the scope of adverse benefit determinations eligible for external review to include determinations that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act and its implementing regulations. In addition, under these interim final rules, grandfathered plans that are not otherwise subject to external review requirements will be subject to external review requirements for coverage decisions that involve whether a plan or issuer is complying with the surprise billing and cost-sharing protections under the No Surprises Act.

Applicability Date and Comment Period

The regulations in the rule are generally applicable to group health plans and health insurance issuers for plan and policy years beginning on or after January 1, 2022. The HHS-only regulations that apply to health care providers, facilities, and providers of air ambulance services are applicable beginning on January 1, 2022. The OPM-only regulations that apply to carriers under the FEHB program are applicable to contract years beginning on or after January 1, 2022. The rules regarding the certification of independent dispute resolution entities and SDR entities are effective from the date the rule is published in the Federal Register.

Written comments on the rule issued on September 30, 2021, must be received by 60 days after the rule is published in the Federal Register to be considered.

Visit the Federal Register to read more about the interim final rule with comment period.

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[1] Cooper, Z. et al., Surprise! Out-of-Network Billing for Emergency Care in the United States, NBER Working Paper 23623, 20173623; Duffy, E. et al., Policies to Address Surprise Billing Can Affect Health Insurance Premiums. The American Journal of Managed Care 26.9 (2020): 401-404; and Brown E.C.F., et al., The Unfinished Business of Air Ambulance Bills, Health Affairs Blog (March 26, 2021),

doi: 10.1377/hblog20210323.911379, available at https://www.healthaffairs.org/do/10.1377/hblog20210323.911379/full/.

[2] Biener, A. et al., Emergency Physicians Recover a Higher Share of Charges from Out-of-network Care than from In-network Care, Health Affairs 40.4 (2021): 622-628.
[3] Sun, E.C., et al. "Assessment of Out-of-Network Billing for Privately Insured Patients Receiving Care in In-network Hospitals." *JAMA Internal Medicine*, 179.11 (2019): 1543-1550. Doi:10.1001/jamainternmed.2019.3451.

[4] States that have enacted balance billing protections include Arizona, Colorado, Delaware, Indiana, Iowa, Maine, Massachusetts, Minnesota, Mississippi, Missouri, New Mexico, North Carolina, Pennsylvania, Rhode Island, Texas, Vermont, and Washington.

[5] https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf.

[6] https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf

[7] A health benefits plan offered under chapter 89 of title 5, United States Code is also known as a Federal Employees Health Benefits plan.

[8] The rules do not apply to people with coverage through programs such as Medicare, Medicaid, Indian Health Services, Veterans Affairs Health Care, or TRICARE. Each of these programs already has other protections against high medical bills.