NO SURPRISE BILLING RULE: WHAT PROVIDERS NEED TO KNOW

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(2/22)

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WRITTEN MATERIALS

Stanger, *No Surprise Billing Rules: Checklist for Providers,* https://www.hollandhart.com/no-surprise-billing-rules-checklist-for-providers?

Stanger, *No Surprise Billing Rules: Good Faith Estimates and Unscheduled Services*, https://www.hollandhart.com/no-surprise-billing-rules-good-faith-estimates-and-unscheduled-services

Part I

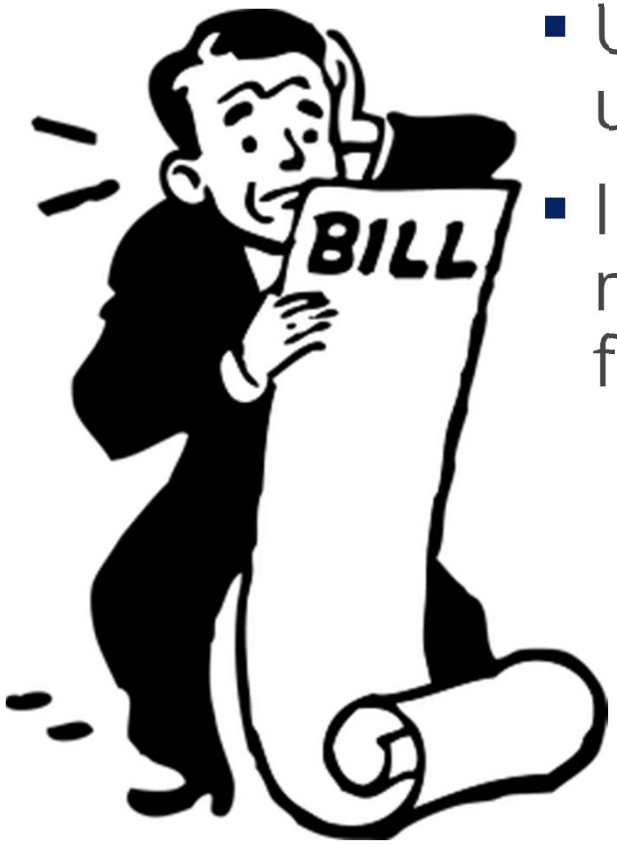
- No Surprise Billing Rule Part I, 86 FR 36872 (7/13/21), https://www.govinfo.gov/app/details/FR-2021-07-13/2021-14379
- HHS, IDR FAQs, https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-IDR-NC-FAQ.pdf

WRITTEN MATERIALS

Part II

- No Surprise Billing Rule Part II, 86 FR 55980 (10/7/21), https://www.govinfo.gov/app/details/FR-2021-10-07/2021-21441
- CMS, Guidance on Good Faith Estimates and PPDR Process (12-21-21), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimate-Patient-Provider-Dispute-Resolution-Process-for-Providers-Facilities-CMS-9908-IFC.pdf
- CMS, Good Faith Estimate FAQs (12-21-21), https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf

PROBLEM: SURPRISE MEDICAL BILLS



- Uninsured or self-pay patient receives unexpected medical bill.
- Insured patient receives unexpected medical bill from out-of-network ("OON") facility or provider:
  - Emergency services rendered by OON facility or provider.
    - E.g., payer limits coverage for emergency services, requires preauthorization, etc.
  - OON providers at in-network facility bill separately from facility.
    - E.g., surgeons, anesthesiology, radiology, pathology, surgical assists, labs, etc.

NO SURPRISE BILLING RULES

Insured Patients

- Limits amount OON provider/facility may bill patient and payer for
  - Emergency services at emergency facility, or
  - Non-emergency services by OON provider at in-network facility, or
  - Air ambulance services.
- Notice of rights to patient.

(Part I, 86 FR 36872 (7/13/21)

- Independent dispute resolution ("IDR") process for OON providers/facilities and payers

(Part II, 86 FR 55980 (9/30/21))

Self-Pay Patients

- Providers/facilities must give patient a good faith estimate of charges.
- Selected dispute resolution ("SDR") *nka* Patient-Provider Dispute Resolution ("PPDR") process if actual bill is substantially in excess of good faith estimate.
- Notice of rights to patient.

(Part II, 86 FR 55980 (9/30/21))

NO SURPRISE BILLING RULES: PENALTIES

- Reduced or denied payment.
  - Insured Patient: limited or denied payment
    - Unable to balance bill patient
    - Limited OON rate from payers
  - Self-Pay Patient: limited or denied payment under the PPDR process
- State enforcement
- If state fails to enforce, HHS may impose:
  - Corrective action plan
  - $10,000 civil penalty

(42 USC 300gg-134(b); 45 CFR 150.101(b)(3), 150.501(a), and 150.513(a))

PART I: INSURED PATIENTS

- OON providers
- Limits on cost-sharing and balance billing patients
- Notice of patient rights concerning balance billing
- Independent Dispute Resolution ("IDR") process with payers

INSURED PATIENTS: OON PAYMENTS TO PROVIDERS

- Only applies to OON providers or facilities when:
  - Emergency services are provided by an OON provider or OON emergency facility.
    - *Facility = emergency dept of hospital or independent freestanding emergency dept as licensed by state (may include urgent care center) (86 FR 36879)*
  - Non-emergency services are provided by an OON provider at an in-network health care facility.
    - *Facility = hospital, hospital outpatient dept, CAH, or ASC that has a contract with a health plan covering the services provided, including single case agreements. (86 FR 36882).*
  - Air ambulance services are furnished by an OON provider of air ambulance services.

(86 FR 36904)

INSURED PATIENTS: LIMITS ON BALANCE BILLING

- Patient's cost-sharing for OON services is no higher than in-network level.
  - E.g., if patient's cost-sharing amount for in-network services is 20%, then patient's cost-sharing amount for OON service is 20%.
- The amount to which cost-sharing applies (i.e., the "recognized amount") is determined in descending order of the following:
  - Amount determined by applicable All-Payer Model Agreement under the SSA; or
  - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
  - If neither of the foregoing apply, the lesser amount of either the billed charge or the *qualifying payment amount* ("QPA").
    - QPA is generally the plan's median contracted rate in 2019 for the same or similar items or services provided by a similar provider in the same geographic region adjusted by CPI.

(45 CFR 149.20 and .140(a)(16) and (c))

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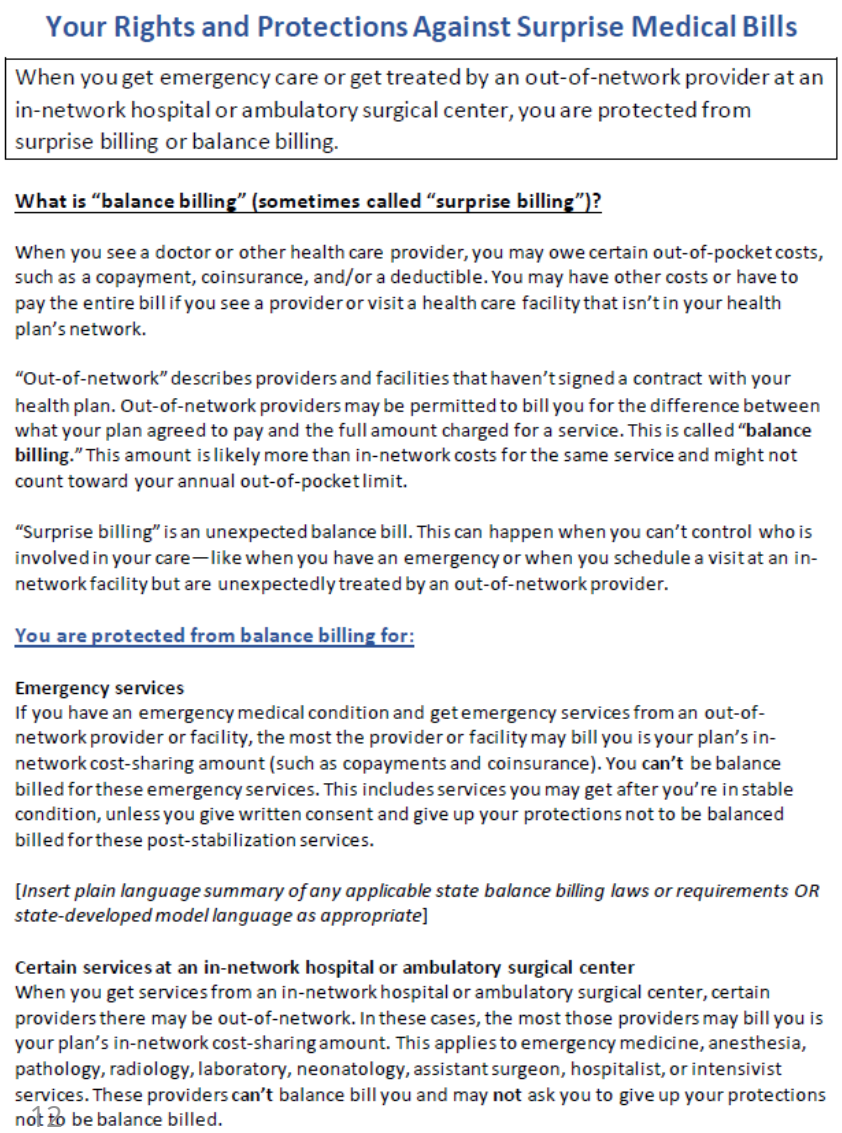
INSURED PATIENTS: LIMITS ON BALANCE BILLING

- OON provider/facility may avoid limits on balance billing if prior to services:
  - Give required written notice of patient rights to patient; and
  - Obtain patient's written informed consent to bill above limits on cost-sharing.
- Notice and consent exception does not apply to certain services, including:
  - Unforeseen, urgent medical needs that arise at time services rendered.
  - Pre-stabilization emergency services.
  - Certain non-emergency services, e.g., anesthesiology, pathology, radiology, neonatology; assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and labs; and items or services provided by OON provider if there is an in-network provider who can furnish them at the facility.
- OON provider/facility must notify insurer if obtain consent to balance bill.

(45 CFR 149.410-.420)

INSURED PATIENTS: NOTICE OF PATIENT RIGHTS



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or get treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from surprise billing or balance billing.

What is "balance billing" (sometimes called "surprise billing")?

When you see a doctor or other health care provider, you may owe certain out-of-pocket costs, such as a copayment, coinsurance, and/or a deductible. You may have other costs or have to pay the entire bill if you see a provider or visit a health care facility that isn't in your health plan's network.

"Out-of-network" describes providers and facilities that haven't signed a contract with your health plan. Out-of-network providers may be permitted to bill you for the difference between what your plan agreed to pay and the full amount charged for a service. This is called **"balance billing."** This amount is likely more than in-network costs for the same service and might not count toward your annual out-of-pocket limit.

"Surprise billing" is an unexpected balance bill. This can happen when you can't control who is involved in your care—like when you have an emergency or when you schedule a visit at an in-network facility but are unexpectedly treated by an out-of-network provider.

You are protected from balance billing for:

Emergency services
If you have an emergency medical condition and get emergency services from an out-of-network provider or facility, the most the provider or facility may bill you is your plan's in-network cost-sharing amount (such as copayments and coinsurance). You **can't** be balance billed for these emergency services. This includes services you may get after you're in stable condition, unless you give written consent and give up your protections not to be balanced billed for these post-stabilization services.

[*Insert plain language summary of any applicable state balance billing laws or requirements OR state-developed model language as appropriate*]

Certain services at an in-network hospital or ambulatory surgical center
When you get services from an in-network hospital or ambulatory surgical center, certain providers there may be out-of-network. In these cases, the most those providers may bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia, pathology, radiology, laboratory, neonatology, assistant surgeon, hospitalist, or intensivist services. These providers **can't** balance bill you and may **not** ask you to give up your protections not to be balance billed.

- Facilities and providers to which the balance bill rule applies must:
  - Post notice on website.
  - Post notice on sign.
  - Give notice to patients in person, mail, or e-mail as determined by patient.

(45 CFR 149.430)

- See HHS form.

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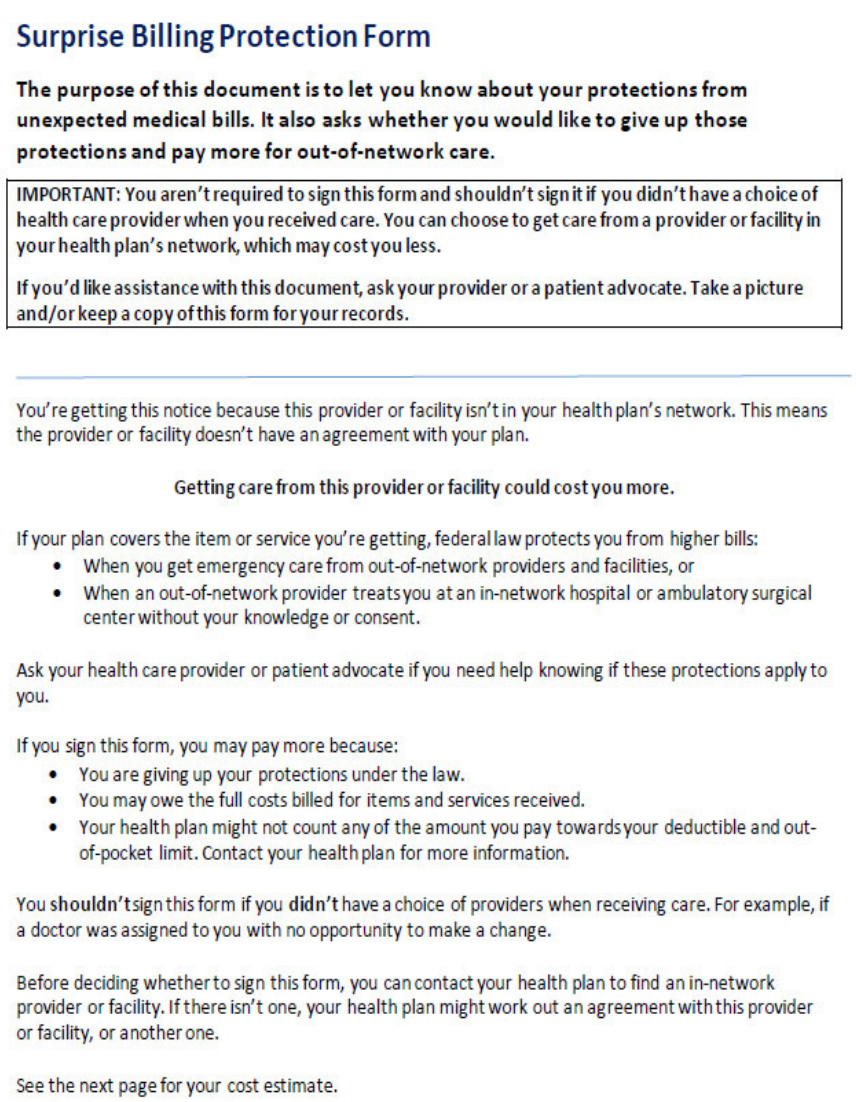
INSURED PATIENTS: NOTICE AND CONSENT FORM



Surprise Billing Protection Form

The purpose of this document is to let you know about your protections from unexpected medical bills. It also asks whether you would like to give up those protections and pay more for out-of-network care.

IMPORTANT: You aren't required to sign this form and shouldn't sign it if you didn't have a choice of health care provider when you received care. You can choose to get care from a provider or facility in your health plan's network, which may cost you less.

If you'd like assistance with this document, ask your provider or a patient advocate. Take a picture and/or keep a copy of this form for your records.

You're getting this notice because this provider or facility isn't in your health plan's network. This means the provider or facility doesn't have an agreement with your plan.

Getting care from this provider or facility could cost you more.

If your plan covers the item or service you're getting, federal law protects you from higher bills:

- When you get emergency care from out-of-network providers and facilities, or
- When an out-of-network provider treats you at an in-network hospital or ambulatory surgical center without your knowledge or consent.

Ask your health care provider or patient advocate if you need help knowing if these protections apply to you.

If you sign this form, you may pay more because:

- You are giving up your protections under the law.
- You may owe the full costs billed for items and services received.
- Your health plan might not count any of the amount you pay towards your deductible and out-of-pocket limit. Contact your health plan for more information.

You **shouldn't** sign this form if you **didn't** have a choice of providers when receiving care. For example, if a doctor was assigned to you with no opportunity to make a change.

Before deciding whether to sign this form, you can contact your health plan to find an in-network provider or facility. If there isn't one, your health plan might work out an agreement with this provider or facility, or another one.

See the next page for your cost estimate.

- Notice and consent must contain certain info.
  - Provider is OON.
  - Good faith estimate of charges.
  - Notice is not a contract.
  - Consent is optional.
  - Patient may receive care from in-network provider.
  - Info about services.

(45 CFR 164.520(c))

➢ See HHS Form.

INSURED PATIENTS: OON PAYMENT TO PROVIDERS

- Total amount paid to OON provider/facility, including any patient cost-sharing amount =
  - Amount determined by applicable All-Payer Model Agreement under the SSA; or
  - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
  - If neither of the foregoing apply, an amount agreed upon by the payer and provider/facility during 30-day "open negotiation" period; or
  - If plan and provider/facility cannot agree, amount determined through independent dispute resolution ("IDR") process.

(*CMS, Requirements Related to Surprise Billing; Part I Interim Final Rule with Comment Period*, https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period)

INSURED PATIENTS: IDR PROCESS

OMB Control No. 1210-0169
Expiration Date: 4/30/2022

Open Negotiation Notice

[Enter date of this notice]

You are receiving this notice because [*Enter name of party initiating negotiations*], a(n) [group health plan, health insurance issuer, Federal employee health benefits (FEHB) carrier, health care provider, health care facility, or provider of air ambulance services] is disputing the out-of-network rate for [*insert appropriate descriptor of the item(s) or service(s)*] provided. More information regarding these items or services is provided below. The No Surprises Act provides a Federal independent dispute resolution (Federal IDR) process that group health plans, health insurance issuers of group and individual health insurance coverage, and FEHB carriers and out-of-network or nonparticipating health care providers, facilities, and providers of air ambulance services may utilize to determine the out-of-network rate for certain services following the end of an open negotiation period. The Federal IDR process is available only for certain services, such as out-of-network emergency services, certain services provided by out-of-network providers at an in-network facility, or air ambulance services. The Federal IDR process is also only available if a state All-Payer Model Agreement or specified state law does not apply.

What is an open negotiation period?

The open negotiation period is a period of up to 30 business days to determine an agreed-upon amount for the total out-of-network rate (including any cost sharing) for an item or service furnished by a nonparticipating provider, nonparticipating facility, or a nonparticipating provider of air ambulance services to a participant, beneficiary, or enrollee in a group health plan, group or individual health insurance policy, or FEHB carrier and for which a payment is required to be made by the plan or coverage.

What happens at the end of the open negotiation period?

If we have not agreed upon a payment amount by the end of the open negotiation period [*insert date 30 business days after the date on the open negotiation notice*], either of us may initiate the Federal IDR process by [*insert date 4 business days after the open negotiation period*], under which a certified IDR entity will select the payment amount for the item(s) and/or service(s) at issue.

Initiating the Federal IDR process does not prohibit us from agreeing on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount.

For more information on the Federal IDR process and to obtain the notice to initiate the Federal IDR process, visit https://www.nsa-idr.cms.gov.

- Within 30 days after receipt of partial payment or denial, send notice starting open negotiating period.
  - Notice must contain required info.
- Attempt to negotiate resolution during 30-day negotiation period.

(45 CFR 149.510(b))

- See DOL form.

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INSURED PATIENT: IDR PROCESS

OMB Control No. 1210-0169
Expiration Date: 4/30/2022

Notice of IDR Initiation

[Enter date of notice]

You are receiving this notice because you were a party to an open negotiation period for [emergency service(s), certain item(s) and service(s) provided by out-of-network provider(s) at an in-network facility, or air ambulance services *insert as appropriate*] that has expired without reaching an agreement for an out-of-network rate for such item(s) and service(s). The [*insert appropriate descriptor* – group health plan, health insurance issuer, Federal Employees Health Benefits (FEHB) carrier, health care provider, health care facility, or provider of air ambulance services] that was also a party to the open negotiation period has decided to initiate the Federal independent dispute resolution (Federal IDR) process. Under the Federal IDR process, a certified IDR entity will now select the out-of-network rate for the item(s) or service(s) at issue if we do not agree on an out-of-network rate. Please note that initiating the Federal IDR process does not prohibit us from reaching an agreement on a payment amount after the open negotiation period has ended and before the certified IDR entity determines the payment amount. For more information on the Federal IDR process, visit https://www.nsa-idr.cms.gov.

In order to initiate the Federal IDR process, a party must submit this Notice of IDR Initiation to the other party within the 4-business-day period beginning on the 31st business day after the start of the open negotiation period.

The initiating party must also furnish the Notice of IDR Initiation to the Departments by submitting notice using the Federal IDR portal, available at https://www.nsa-idr.cms.gov. **The initiation date of the Federal IDR process will be the date of receipt of the Notice of IDR Initiation by the Departments.**

After notice is provided to the Departments, you and the initiating party will have no more than 3 business days to mutually agree on a certified IDR entity.[1] This notice indicates the initiating party's preferred certified IDR entity. You and the initiating party may agree to use this certified IDR entity, or you and the initiating party may agree to use another certified IDR entity. If you and the initiating party are unable to agree on a certified IDR entity to be selected within the 3-business-day time frame, then the Departments will select a certified IDR entity through a random selection method.

Within 4 business days of initiation, the parties must electronically submit the notice of the certified IDR entity selection or failure to select to the Departments using the Federal IDR portal, available at https://www.nsa-idr.cms.gov. If the parties have selected a certified IDR entity, the notice of selection must include: (1) the name of the certified IDR entity; (2) the certified IDR entity number (a unique identification number assigned to each certified IDR entity by the Departments); and (3) an attestation by the parties (or by the initiating party if the other party did not respond) that the selected certified IDR entity does not have a disqualifying conflict of interest. If the parties have failed to select a certified IDR entity, the notice should indicate that the parties have failed to select a certified IDR entity. If you believe that the Federal IDR process is not applicable, you must also provide information regarding the lack of applicability on the same timeframe that the notice of selection (or failure to select) is required. You may obtain a copy of the notice of the certified IDR entity selection or failure to select at https://www.nsa-idr.cms.gov. If the party in receipt of the notice of IDR initiation fails to object within 3 business days, the preferred certified IDR entity identified in the notice of IDR initiation will be

- If cannot agree during 30-day open negotiate period, request IDR by filing notice within 4 business days after 30-day open negotiation period ends.
  - Notice must contain required info.

(45 CFR 149.510(b))

- See DOL Form

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INSURED PATIENT: IDR PROCESS

- Within 3 business days after IDR initiated, the parties may agree or object to the IDR entity.
  - E.g., conflict of interest.
- Within 4 days after IDR initiated, initiating party must notify HHS of IDR entity if parties agreed.
- Within 4 days after IDR initiated, receiving party must submit any objections to IDR process.
- Within 6 days after IDR initiated, if parties fail to agree to IDR entity, HHS will appoint the IDR entity.
  - IDR entity's fees may be greater than if selected by parties.
- Parties must pay IDR administrative fee set by HHS.
- If parties agree on OON rate while IDR is pending, they most notify HHS within 3 days after agreement.
- IDR amounts may be submitted in batches or bundled payment arrangements.

(45 CFR 149.510(c))

INSURED PATIENTS: IDR PROCESS

- Within 10 days after IDR entity selected, each party submits OON rate offer.
  - Both in dollar amount and % of QPA.
  - Info requested by IDR entity.
  - Additional info as appropriate:
    - Size of practice or facility (i.e., number of employees)
    - Practice specialty
    - QPA for the applicable year for the same or similar item or service.
  - Additional info the party believes is appropriate.
- Both parties submit IDR entity's fee.
  - Winner receives a refund.

(45 CFR 149.510(c)(4))

INSURED PATIENTS: IDR PROCESS

- Within 30 days after IDR entity selected, IDR issues written decision selecting one of the offers based on:
  - QPA for applicable year for same or similar item/service.
  - Info requested by IDR entity.
  - Additional info submitted by parties relating to:
    - Provider's training, experience, quality, outcomes.
    - Market share.
    - Acuity of patient or complexity of item/service.
    - Facility's teaching status, case mix scope of services.
    - Prior network agreements between the parties.
  - Additional info submitted by parties.
  - Info must be credible.

(45 CFR 149.510(c))

INSURED PATIENTS: IDR PROCESS

- *IDR is skewed heavily in favor of QPA.*
  - "IDR entity must select the offer closest to the QPA, unless the credible info submitted by the parties clearly demonstrates that the QPA is materially different from the appropriate OON rate…"

  (86 FR 55995)
  - Additional info must clearly demonstrate that the QPA is materially different from the appropriate OON rate.
  - If IDR entity does not choose the offer closest to the QPA, the IDR entity's written decision must explain how the credible info demonstrates that the appropriate OON is materially different from the QPA.

  (45 CFR 149.510(c)(4)(vi)(B))
- AMA, AHA, and others have sued HHS challenging the QPA presumption. (*AMA v. HHS* (D.C. Dist.))

INSURED PATIENTS: IDR PROCESS

- Effect of decision:
  - Binding on parties absent fraud or intentional misrepresentation of a material fact.
  - Not subject to judicial review.
  - Party who initiated IDR may not initiate another IDR involving same party and same or similar claims for 90 days.
- Within 30 days of decision:
  - Loser pays balance due other party.
  - Loser remains responsible for IDR entity fee.
  - Winner's prepaid fee is refunded.

(45 CFR 149.510(c)(4)(vii)-(ix))

PART II: UNINSURED OR SELF-PAY PATIENTS

- Good faith estimate
- Patient-Provider Dispute Resolution ("PPDR") process

SELF-PAY PATIENTS: INQUIRE IF PATIENT IS SELF-PAY

- Convening provider/facility must:
  - Determine if an individual is uninsured or a self-pay individual:
    - Ask if the patient is covered by a group plan, insurance or a federal healthcare program.
    - If patient has coverage, ask if patient wants to have the claim submitted to the payer for the primary item or service.
  - If patient is self-pay, inform the patient that they may obtain a good faith estimate of expected charges upon:
    - Scheduling the item or service, or
    - Upon request.

(45 CFR 149.610(b)(1))

SELF-PAY PATIENTS: NOTICE OF GOOD FAITH ESTIMATE

- Convening provider/facility must inform self-pay patients about right to good faith estimate by:
  - Written notice prominently displayed
    - On provider/facility's website;
    - In its office; and
    - Onsite where scheduling or questions about cost of items or services occur.
  - Orally inform patient when scheduling item or service or when patient asks about cost of items or services.
- Notice must be made available in accessible formats and the language spoken by the patient.

(45 CFR 149.610(b)(1))

SELF-PAY PATIENTS: NOTICE OF GOOD FAITH ESTIMATE

OMB Control Number [XXXX-XXXX]
Expiration Date [MM/DD/YYYY]

You have the right to receive a "Good Faith Estimate" explaining how much your medical care will cost

Under the law, health care providers need to give **patients who don't have insurance or who are not using insurance** an estimate of the bill for medical items and services.

- You have the right to receive a Good Faith Estimate for the total expected cost of any non-emergency items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- Make sure your health care provider gives you a Good Faith Estimate in writing at least 1 business day before your medical service or item. You can also ask your health care provider, and any other provider you choose, for a Good Faith Estimate before you schedule an item or service.
- If you receive a bill that is at least $400 more than your Good Faith Estimate, you can dispute the bill.
- Make sure to save a copy or picture of your Good Faith Estimate.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises or call [INSERT PHONE NUMBER].

- See HHS form.

SELF-PAY PATIENTS: PROVIDE GOOD FAITH ESTIMATE

- If self-pay person
  - Requests a good faith estimate (including inquiry or discussion about costs), or
  - Upon scheduling a primary item or service,

  convening facility must:
  - Within 1 business day, ask co-providers/facilities to submit good faith estimate to the convening provider/facility by due date.*
  - Timely provide written good faith estimate to the patient.

(45 CFR 149.610(b)(1))

** Rules re co-providers not enforced until 1/1/23.*

SELF-PAY PATIENTS: PROVIDE GOOD FAITH ESTIMATE

- If item/service scheduled at least 3 days in advance, provide good faith estimate not later than 1 business day after the date of scheduling.
- If item/service scheduled at least 10 days in advance, provide good faith estimate not later than 3 business days after the date of scheduling.
- If patient requests good faith estimate, provide good faith estimate not later than 3 business days after the date of the request.
- If patient requested good faith estimate and then schedules services, must provide new good faith estimate within time frames described above.
- If any change to anticipated charges, must provide updated good faith estimate no later than 1 business day before the items/services are scheduled to be rendered.

(45 CFR 149.610(b)(1))

SELF-PAY PATIENTS: PROVIDE GOOD FAITH ESTIMATE

"There are some items or services that may not be included in a GFE because they are not typically scheduled in advance and not typically the subject of a requested GFE (such as urgent, emergent trauma, or emergency items or services); however, to the extent that such care is scheduled at least 3 days in advance, a provider or facility would be required to provide a GFE.

"For example, individuals will likely not be able to obtain GFEs for emergency air ambulance services, as these are not generally scheduled in advance. However, making these requirements applicable to providers of air ambulance services helps to ensure that individuals can obtain a GFE upon request or at the time of scheduling non-emergency air ambulance services…"

(HHS, Good Faith Estimate FAQs, available at https://www.cms.gov/CCIIO/Resources/Regulations-and-Guidance/Downloads/Guidance-Good-Faith-Estimates-FAQ.pdf)

SELF-PAY PATIENTS: PROVIDE GOOD FAITH ESTIMATE

- If convening providers/facilities or co-providers/facilities listed in good faith estimate change less than 1 business day before the item/service is scheduled to be provided:
  - Replacement provider/facility must accept the existing good faith estimate as its good faith estimate.
  - Replacement providers/facilities are bound by the existing good faith estimate.

(45 CFR 149.610(b)(1)(viii)-(2)(iii))

➢ *Replacement providers should review good faith estimate and provide new good faith estimate if there is time.*

SELF-PAY PATIENTS: GOOD FAITH ESTIMATE

OMB Control Number [XXXX-XXXX]
ExpirationDate [MM/DD/YYYY]

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient		
Patient First Name	Middle Name	Last Name
Patient Date of Birth: _____/_____/_____		
Patient Identification Number:		
Patient Mailing Address, Phone Number, and Email Address		
Street or PO Box		Apartment
City	State	ZIP Code
Phone		
Email Address		
Patient's Contact Preference: [ ] By mail [ ] By email		
Patient Diagnosis		
Primary Service or Item Requested/Scheduled		
Patient Primary Diagnosis		Primary Diagnosis Code
Patient Secondary Diagnosis		Secondary Diagnosis Code

- Good faith estimate must include required info:
  - Patient name and birthdate;
  - Items and services by codes and charges.
  - Discounts or adjustments.
  - Name, NPI, TIN of co-provider/facility,
  - Location where each item/service is provided;
  - List of items/services that will require separate scheduling; and
  - Disclaimers

(45 CFR 149.610(c))

- See HHS form

➢ ***Make sure good faith estimate is accurate and complete because you are likely going to be bound by it…***

SELF-PAY PATIENT: GOOD FAITH ESTIMATE

- Maintain the good faith estimate as part of the patient's medical record for 6 years.
- Provide the good faith estimate to patient if requested within 6 years.

(45 CFR 149.610(f)(1))

SELF-PAY PATIENTS: GOOD FAITH ESTIMATES

- If actual charges are "substantially in excess" of good faith estimate (i.e., at least $400 more than expected charges), patient may initiate selected dispute resolution ("SDR") *nka* patient-provider dispute resolution ("PPDR") process.

(45 CFR 149.620).

SELF-PAY PATIENTS: PPDR PROCESS

- Within 120 days of receiving bill containing disputed charges, patient must notify HHS of intent to pursue PPDR and pay $25 fee.
- If PPDR entity determines PPDR is appropriate, it will notify provider/facility.
- While PPDR pending, provider/facility may not:
  - Move the disputed bill to collections or threaten to do so;
  - If bill moved to collections, cease collection efforts;
  - Suspend accrual of late fees on unpaid bill amounts;
  - Take or threaten any retribution against patient to obtain resolution of dispute.

(45 CFR 149.620(c)(1)-(2))

SELF-PAY PATIENTS: PPDR PROCESS

- Within 10 days of notice to provider, provider must submit to PPDR entity:
  - Copy of the good faith estimate relevant to dispute.
  - Copy of the billed charges that are subject to dispute.
  - If available, documentation showing that the difference between billed charge and good faith estimate reflects:
    - Cost of medically necessary item/services; and
    - There were unforeseen circumstances that could not have reasonably been anticipated by provider/facility when the good faith estimate was provided.

- Within 30 days, PPDR entity issues decision.

(45 CFR 149.620(c), (f))

SELF-PAY PATIENTS: BILLED CHARGE IS ON ESTIMATE

If billed charge is listed on the good faith estimate:

- If billed charge ≤ expected charge:
  - Patient pays the billed charge
- If billed charge > expected charge and provider failed to prove medical necessity and unforeseeability:
  - Patient pays the expected charge from estimate.
- If billed charge > expected charge and provider proves medical necessity and unforeseeability:
  - Patient pays the lesser of the:
    - Billed charge, or
    - Expected charge if expected charge > median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database, or
    - Median rate if expected charge < median rate.

(45 CFR 149.620(f)(3)(iii)(A))

SELF-PAY PATIENTS: BILLED CHARGE NOT ON ESTIMATE

If billed charge is not listed on good faith estimate:

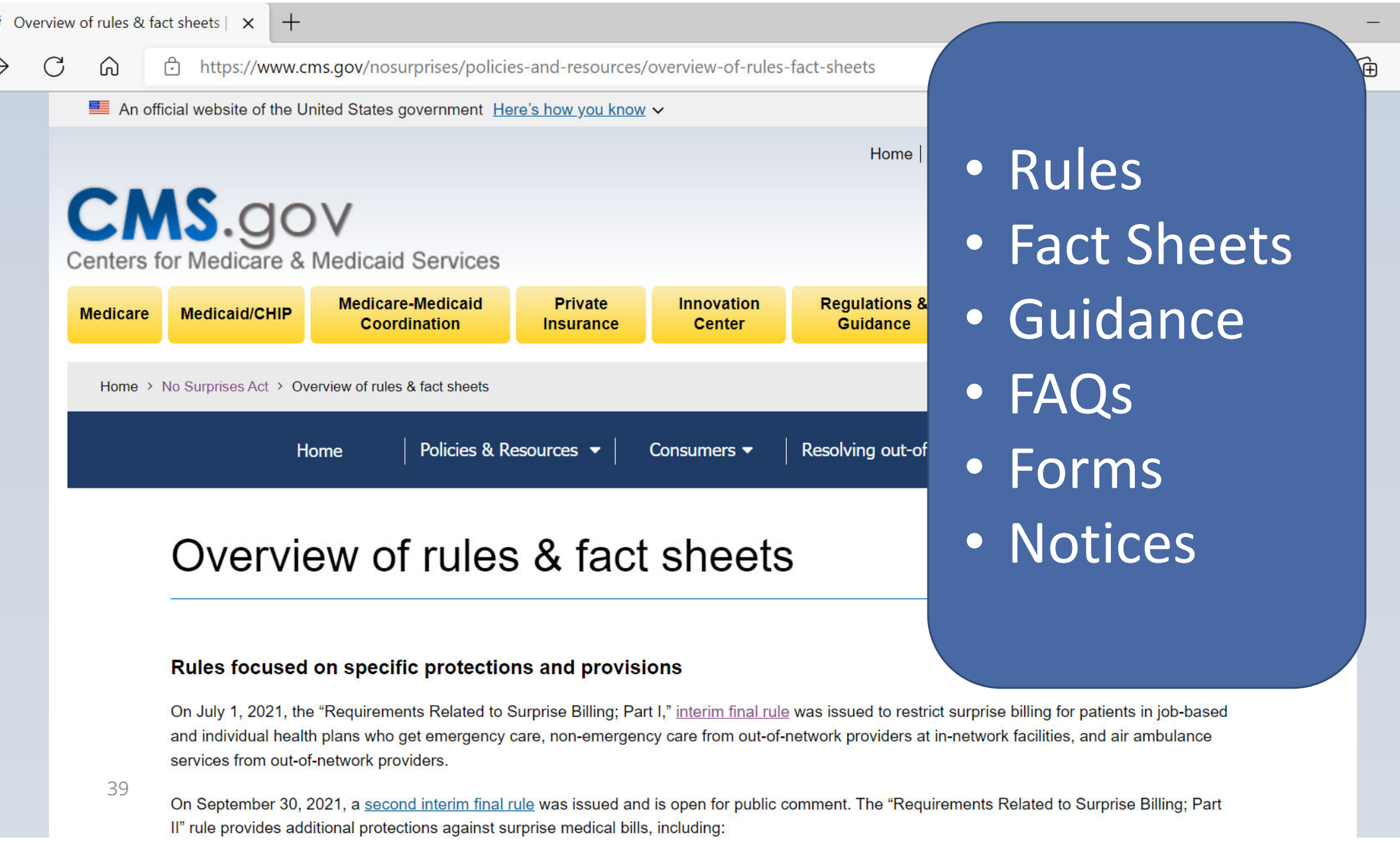
- If provider failed to prove medical necessity and unforeseeability:
  - Patient pays $0 for the item/service.
- If provider proves medical necessity and unforeseeability:
  - Patient pays the lesser of the:
    - Billed charge, or
    - Median rate paid by a payer for same/similar service by same/similar provider in the geographic area as listed in independent database.

(45 CFR 149.620(f)(3)(iii)(B))

HTTPS://WWW.CMS.GOV/NOSURPRISES

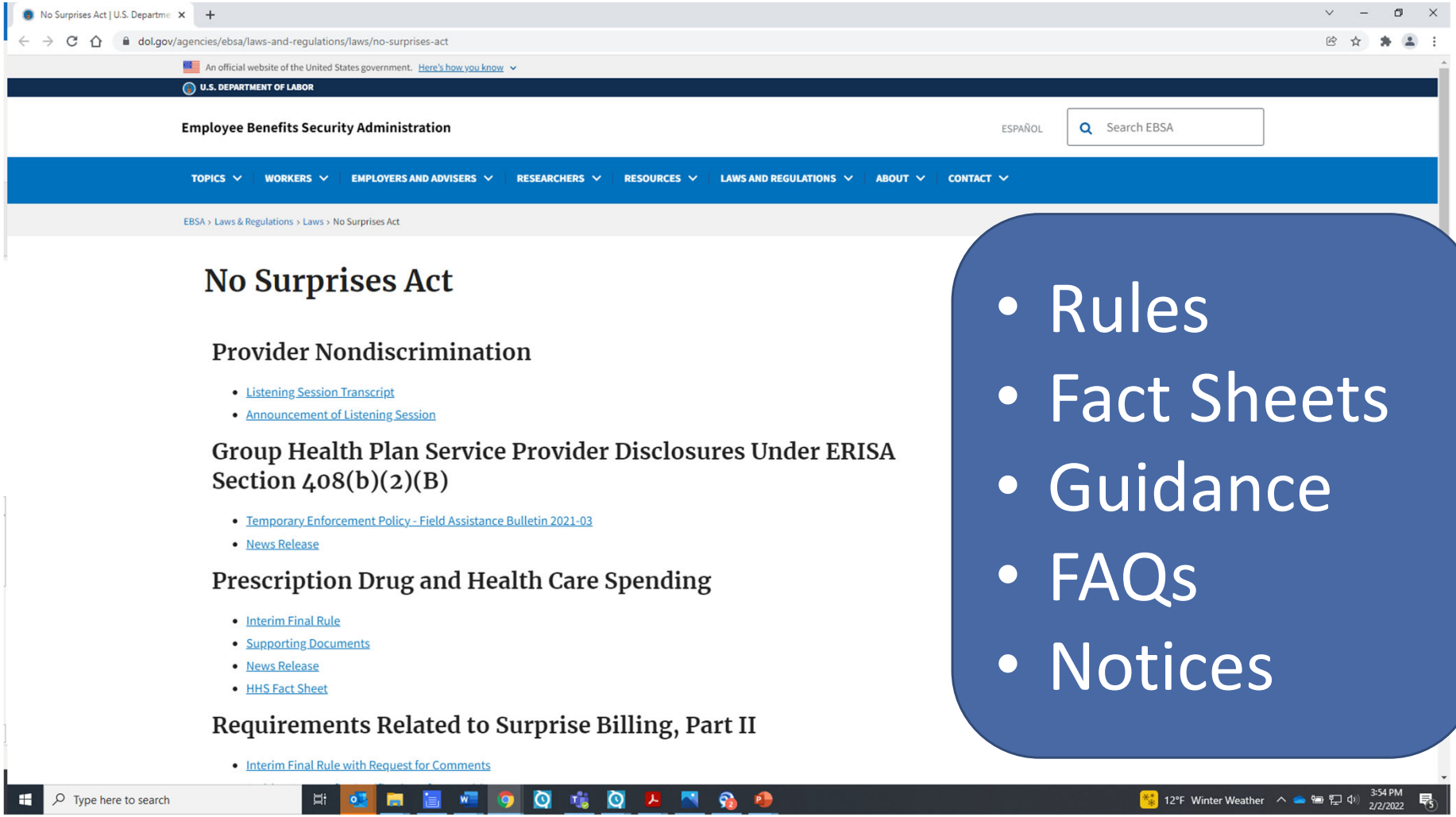
ADDITIONAL RESOURCES

HTTPS://WWW.CMS.GOV/NOSURPRISES/POLICIES-AND-RESOURCES/OVERVIEW-OF-RULES-FACT-SHEETS



- Rules
- Fact Sheets
- Guidance
- FAQs
- Forms
- Notices

HTTPS://WWW.DOL.GOV/AGENCIES/EBSA/LAWS-AND-REGULATIONS/LAWS/NO-SURPRISES-ACT



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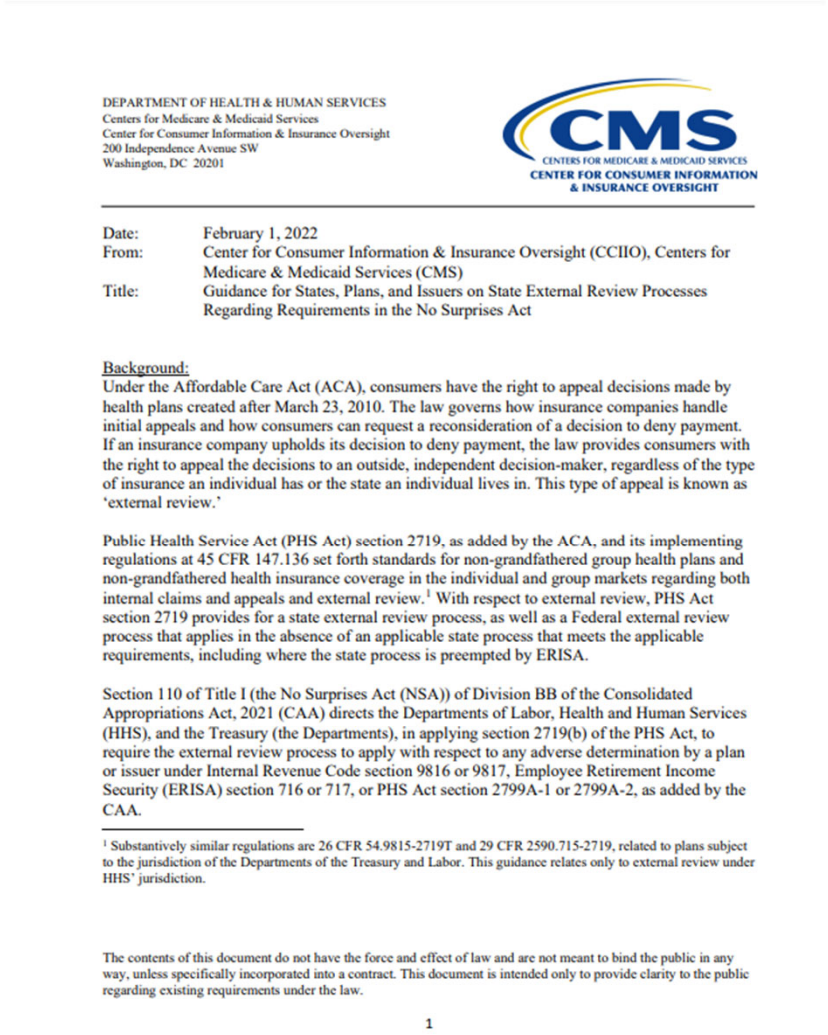
HTTPS://WWW.CMS.GOV/CCIIO/RESOURCES/REGULATIONS-AND-GUIDANCE/DOWNLOADS/NSA-GUIDANCE.PDF



DEPARTMENT OF HEALTH & HUMAN SERVICES
Centers for Medicare & Medicaid Services
Center for Consumer Information & Insurance Oversight
200 Independence Avenue SW
Washington, DC 20201

CMS
CENTERS FOR MEDICARE & MEDICAID SERVICES
CENTER FOR CONSUMER INFORMATION & INSURANCE OVERSIGHT

Date: February 1, 2022
From: Center for Consumer Information & Insurance Oversight (CCIIO), Centers for Medicare & Medicaid Services (CMS)
Title: Guidance for States, Plans, and Issuers on State External Review Processes Regarding Requirements in the No Surprises Act

Background:
Under the Affordable Care Act (ACA), consumers have the right to appeal decisions made by health plans created after March 23, 2010. The law governs how insurance companies handle initial appeals and how consumers can request a reconsideration of a decision to deny payment. If an insurance company upholds its decision to deny payment, the law provides consumers with the right to appeal the decisions to an outside, independent decision-maker, regardless of the type of insurance an individual has or the state an individual lives in. This type of appeal is known as 'external review.'

Public Health Service Act (PHS Act) section 2719, as added by the ACA, and its implementing regulations at 45 CFR 147.136 set forth standards for non-grandfathered group health plans and non-grandfathered health insurance coverage in the individual and group markets regarding both internal claims and appeals and external review.[1] With respect to external review, PHS Act section 2719 provides for a state external review process, as well as a Federal external review process that applies in the absence of an applicable state process that meets the applicable requirements, including where the state process is preempted by ERISA.

Section 110 of Title I (the No Surprises Act (NSA)) of Division BB of the Consolidated Appropriations Act, 2021 (CAA) directs the Departments of Labor, Health and Human Services (HHS), and the Treasury (the Departments), in applying section 2719(b) of the PHS Act, to require the external review process to apply with respect to any adverse determination by a plan or issuer under Internal Revenue Code section 9816 or 9817, Employee Retirement Income Security (ERISA) section 716 or 717, or PHS Act section 2799A-1 or 2799A-2, as added by the CAA.

[1] Substantively similar regulations are 26 CFR 54.9815-2719T and 29 CFR 2590.715-2719, related to plans subject to the jurisdiction of the Departments of the Treasury and Labor. This guidance relates only to external review under HHS' jurisdiction.

The contents of this document do not have the force and effect of law and are not meant to bind the public in any way, unless specifically incorporated into a contract. This document is intended only to provide clarity to the public regarding existing requirements under the law.

1

- CMS External Review Guidance Regarding State Processes
  - On February 1, 2022, CMS issued guidance for States, Plans, and Issuers.
  - As previously discussed, CMS is allowing the States to be the primary enforcer of the Rules. So, it is helpful to know how the States will enforce the Rules.

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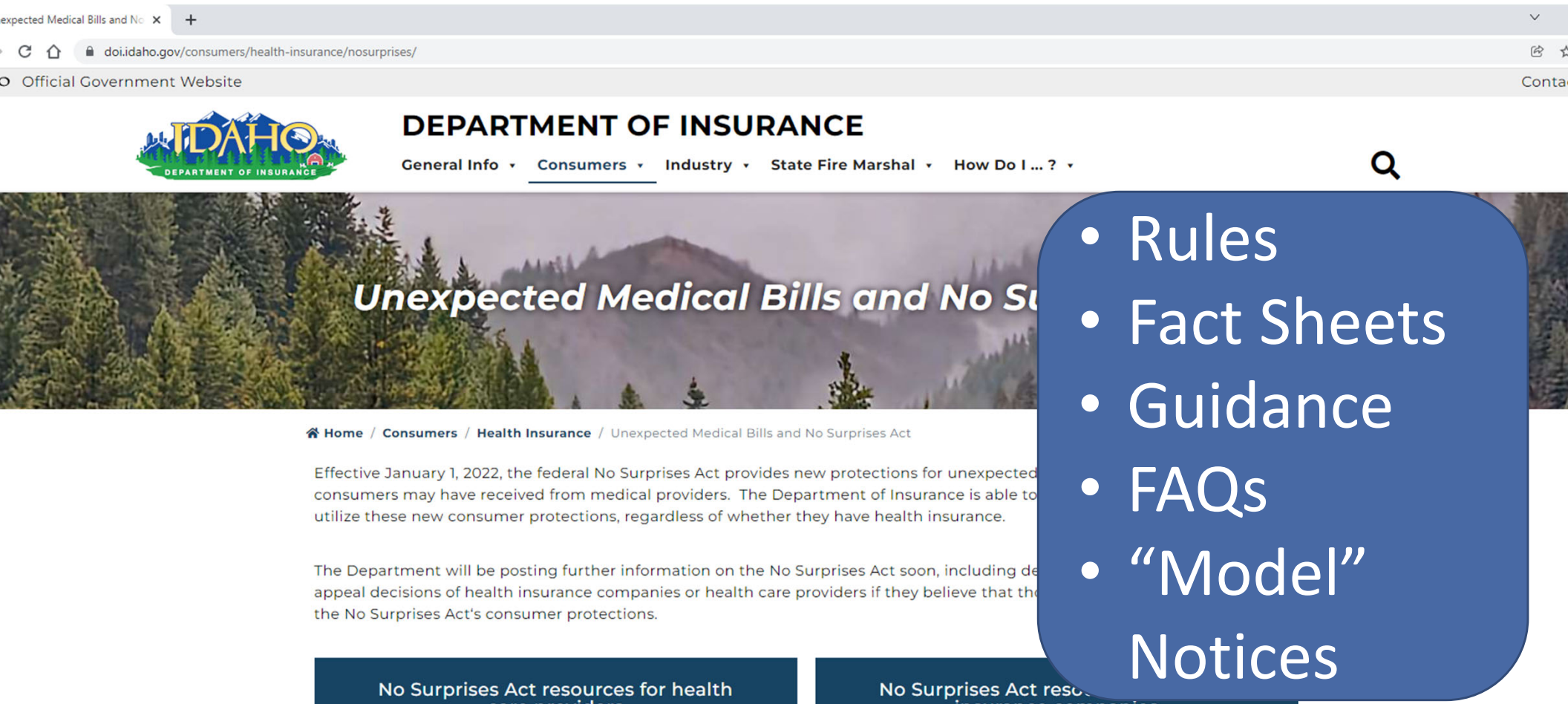

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- Guidance
- FAQs
- "Model" Notices

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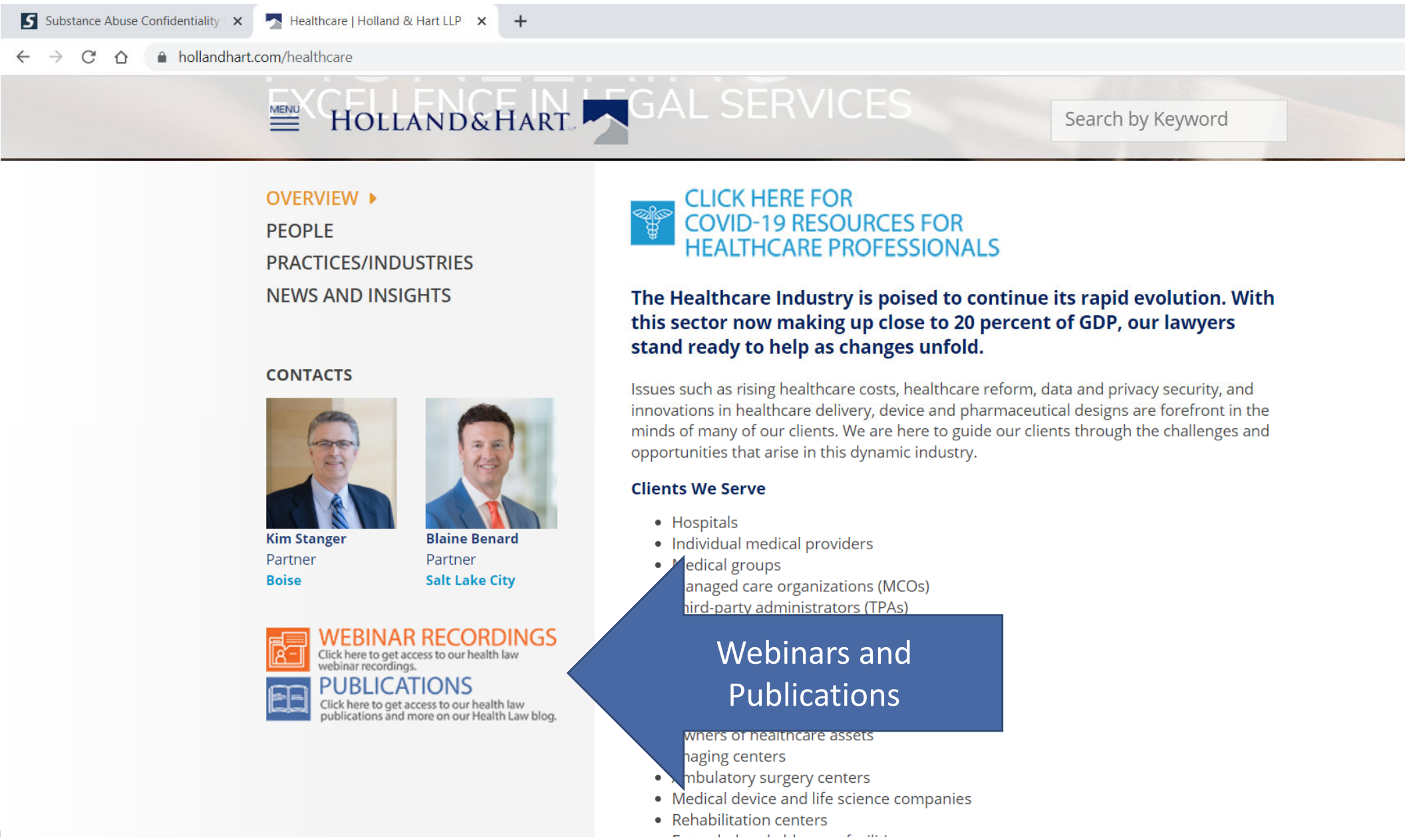

QUESTIONS?

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