AHPA
ADVENTIST HEALTH POLICY ASSOCIATION

Summary: Surprise Billing Interim Final Rule; Part 1

The Department of Health and Human Services (HHS), along with other federal agencies, have released "Part 1" of regulations implementing the No Surprises Act, which was enacted as part of the Consolidated Appropriations Act of 2021. The interim final rule addresses several provisions in the law, including the ban on balance billing for certain out-of-network services (referred to as "surprise medical bills") and the formula for calculating Qualifying Payment Amounts (QPAs). This rule does *not* address other policies of the No Surprises Act, including the creation of an Independent Dispute Resolution (IDR) process. **Comments are due September 7th**. To review the interim final rule, click here.

Key Proposals

Balance Billing Prohibition

- Prohibit out-of-network providers from billing patients more than their in-network cost-sharing amount for all emergency services and certain non-emergency services.
    - Services provided to a patient *post-stabilization* are subject to the balance billing protections until the point of discharge, transfer, or consent by the patient to be balance billed, unless certain conditions are met.
        - **The rule seeks comment on the definition of "reasonable travel distance" and whether specific standards or examples should be provided regarding what constitutes an unreasonable travel burden.**
    - There are cases where commercial health plans have implemented policies that restrict coverage for emergency services that are inconsistent with the prudent layperson standard established by the Affordable Care Act.[1] The rule states that these policies are inconsistent with the requirements of the No Surprises Act, as well as the prudent layperson standard.
- Expands the definition of emergency services to include services provided by a freestanding emergency department and post-stabilization services. The limitations on balance billing and cost-sharing may be waived if the patient consents to receive the services knowing that they are out-of-network.
- **The rule solicits comments on:**
    - *Whether there are any additional conditions that should be included the definition of emergency services.*
    - *What guidelines may be needed to determine when an individual is in condition to receive the written notice and provide consent (e.g. whether standards are needed to account for individuals who are experiencing severe pain, intoxication, incapacitation, or dementia after being stabilized).*

[1] The Prudent Layperson Standard defines an emergency medical condition as a medical condition manifesting itself by acute symptoms of sufficient severity such that a prudent layperson could reasonably expect the absence of immediate medical attention to result in placing the patient's health in serious jeopardy.

Qualifying Payment Amount (QPAs)

- Establish a formula to calculate the QPA, which is used to determine a patient's cost-sharing and will be a factor for consideration in the IDR process to be developed in future rulemaking.
    - The No Surprises Act defines QPA as the median of contracted rates for a given service in the same geographic region within the same insurance market across all of a health plan as of January 31, 2019, increased for inflation.
        - If a health plan does not have sufficient contracted rates in a Metropolitan Statistical Area (MSA), the health plan must consider all MSAs in the state as one region.
    - The regulations address how the QPA will be trended forward and how to account for contracts using value-based payment methodologies or where services are reimbursed on a per-unit basis.
    - The QPA will *not* vary based on facility type (e.g. small versus large hospital). The only exception to this proposal is for hospital-based emergency departments and independent freestanding emergency departments.
    - Health plans are required to exclude risk sharing, bonus/penalty and other incentive-based and payment adjustments from the QPA calculation.
    - Plans and issuers must have at least three contracted rates on January 31, 2019, to calculate the QPA.
- **The rule seeks comments on all aspects of the proposed methodology for determining the QPA, including:**
    - *Whether there are any considerations or factors that are not sufficiently accounted for in the methodology.*
    - *The impact of the methodology on cost sharing, payment amounts and provider network participation.*
    - *Areas where commenters believe additional rulemaking or guidance is necessary.*
    - *The impact of large consolidated health care systems on contracted rates and the impact of such contracted rates on prices and the QPA.*
- Require payers to disclose to out-of-network providers the QPA for each item or service. Payers are also required to:
    - Make certain disclosures with each initial payment or notice of denial payment, as well as provide additional information upon the provider's request.
    - Give providers the option to initiate a 30-day open negotiation period for determining the total payment. If the 30-day open negotiation period does not result in a determination, the provider may initiate the IDR process within four days after the negotiation period is over.
- **The rule seeks comments on what additional information a plan or issuer should be required to share with a provider or facility about the QPA, either in all cases or upon request.**

Provider Reimbursement

- Require health plans to make an initial payment (or notice of denial) to providers within 30 calendar days of receiving a "clean claim." The rule does *not* establish how much plans must reimburse providers for out-of-network claims.

- **The rule seeks comments on whether a minimum payment amount should be established for out-of-network claims and if so, what methodology could be used. Options listed as examples in the rule include:**
    - *A specific percentage of the Medicare rate or a specific percentage of the plan or issuer's Qualifying Payment Amount (QPA) for the item or service.*
    - *An amount calculated in the same way the plan or issuer typically calculates payment for the specific item or service to nonparticipating providers or facilities.*
    - *A "commercially reasonable rate" without requiring a specific methodology.*

Patient Consent for Certain Out-of-Network Providers

- Establish a process for certain out-of-network providers to obtain patient consent to balance bill.
    - The law permits patients to waive the balance billing protections if the out-of-network provider notifies the patient and obtains the patient's consent.
    - This process cannot be used for certain services, including emergency services (with exception of certain post-stabilization services), certain ancillary services, and services that are delivered as a result of an unforeseen urgent medical need (e.g. complications from a knee surgery in which the patient had initially waived the balance billing protections).
    - The notice must be provided at least 72 hours before a medical service is rendered and be available both electronically and in paper. A representative of the provider must be physically present or available by phone to answer questions.
    - **The rule seeks comments on the appropriate balance between allowing a specialist to refuse to treat an individual unless the specialist can balance bill the individual, while ensuring the individual is not pressured into waiving the balance billing protections.**
- The notice and consent form must include a good faith estimate of the out-of-network charges, whether prior authorization is required by the patient's health plan, and a list of any in-network providers who are able to furnish the items or services. The notice must also be available in the top 15 languages of the state or region in which the provider is located.
- Facilities and providers must use the standard forms provided by HHS with only minimal modification. HHS is accepting comments on these forms until August 12th.
- Require providers to submit a copy of the signed notice and consent forms to the patient's health plan and retain such documents for at least seven years.

Complaint Process for Violations

- Establish a complaint process for potential violations of any of these provisions.
    - The complaint process will apply to health plans, providers, facilities and providers of air ambulance services. The federal government will have 60 days to respond to the complaint and may seek additional information from any of the stakeholders involved.
    - There will be no statute of limitations on the time frame for submitting a complaint.
    - **The rule seeks comment on:**
        - *Whether a time limit for filing complaints should be established and if so, how long the time period should be.*

        - *Whether this complaint process should apply only to the QPA or should be extended to all consumer protections and balance billing requirements.*
        - *What information should be required to file a complaint.*

Interactions Between Federal and State Law

- Clarify the interaction between state and federal laws. Examples of how the requirements would interact with state law are also provided in the rule.
    - The rule states that these provisions apply to all forms of commercial coverage except in instances where states have surprise medical billing protections in place for state-regulated plans.
    - These regulations do *not* apply to the Medicare and Medicaid programs, as protections against balance billing already exist in those programs.
    - The No Surprises Act is not intended to displace states' balance billing laws, including any state processes for calculating out-of-network rates.
    - **The rule seeks comment on whether providers should be permitted to opt into a state's program of regulatory protections against surprise billing or whether such flexibility would result in providers selectively opting into state programs that favor their own payments.**

Yet to be Addressed (Coming Soon)

- The IDR process
    - The IDR process authorized by the No Surprises Act will be used if providers want to challenge claims that plans/issuers deny on another basis.
- Good faith estimates
    - The regulations stipulate that the provider/facility must use the same process to develop the good faith estimate as will be required to meet the other price transparency provisions in the No Surprises Act.
- Advanced explanation of benefits
- Provider directories
- Continuity of care