Illinois Health and Hospital Association

July 26, 2021

ILLINOIS HEALTH AND HOSPITAL ASSOCIATION
M E M O R A N D U M

SUBJECT: IHA Summary: No Surprises Act: Implementing Regulations Part 1

As part of the *Consolidated Appropriations Act of 2021*, the No Surprises Act outlines new patient protections from surprise medical bills and requirements for health care providers and plans. The provisions apply to both state-regulated individual and group health plans and self-funded Employee Retirement Income Security Act (ERISA) plans. Most provisions in the Act are effective Jan. 1, 2022 and require the issuance of implementing regulations. IHA's summary of the No Surprises Act is on IHA's Finance *website*.

Implementing Regulations, Part 1

The Office of Personnel Management and the U.S. Departments of Health and Human Services (HHS), Labor, and Treasury (the Departments) published *Part 1* of the implementing regulations in the *Federal Register* on July 13 as an interim final rule with comment period (IFC). Comments on the IFC are due Sept. 7, and comments on the *draft standard notice and consent documents* are due Aug. 12.

The IFC addresses several provisions of the No Surprises Act, including the ban on balance billing for certain out-of-network services, the notice and consent process necessary to balance bill patients for certain out-of-network services, provider reimbursement for out-of-network services, calculating patient cost sharing, and the complaint process for potential violations of this law. We expect implementing regulations on the independent dispute resolution (IDR) process, developing good faith estimates, providing advanced explanations of benefits, maintaining provider directories, and ensuring continuity of care via regulations later this calendar year.

Illinois' Surprise Billing Law (Public Act 96-1523)

In general, the IFC states that the regulations in this final rule apply except when states have surprise medical billing protections in place that are as stringent, or more stringent, than the No Surprises Act. Such state laws must also include a method for determining the amount paid to an out-of-network provider. In such cases, the state's law takes precedent, so long as the state's law applies to the plan, provider, and item or service involved.

In 2011, Illinois amended the Illinois Insurance Code, implementing certain patient protections against balance billing via *Public Act 96-1523*. This law bans balance billing for anesthesiology, emergency, neonatology, pathology and radiology services provided at in-network hospitals or ambulatory surgery centers (ASCs). Patients must be billed as though in-network providers furnished such services for cost sharing purposes, and the payer (health plan or issuer) may pay either the billed amount or attempt to negotiate reimbursement with the provider. If

negotiations do not result in an agreed-upon payment amount, then the payer or the provider may initiate a binding arbitration process by filing a request with the Department of Insurance. Importantly, the Illinois law does not apply to ERISA health plans or group or individual health plans that are self-funded.

No Surprises Act Ban on Balance Billing

The No Surprises Act establishes a ban on balance billing that is more comprehensive than Illinois' law, in terms of both the insured individuals protected and the services covered.

Applicable Providers

No Surprises Act requirements and this IFC apply to facilities, providers furnishing services at a facility, and air ambulance providers. Facilities include hospitals, hospital outpatient departments, critical access hospitals (CAHs), freestanding emergency departments and ASCs. Facility providers include assistant surgeons, hospitalists, and intensivists, in addition to physicians and providers of services covered by surprise billing protections under the No Surprises Act (e.g., anesthesiologists). Provisions specific to ambulance services only pertain to air ambulance services at this time (not ground ambulance services). Note that urgent care centers are not currently applicable providers, and the Departments seek comment on whether this should change.

Applicable Health Plans

The IFC outlines applicable health care coverage as follows: group health plans, individual and small group market coverage, and the Federal Employees Health Benefits (FEHB) Program. Group health plans include both insured and self-insured group health plans, including private employment-based group health plans subject to ERISA, non-federal governmental plans (e.g., plans sponsored by states and local governments), and church plans subject to the Internal Revenue Service (IRS) code. Individual health insurance coverage includes coverage offered in the individual market, through or outside of the federal health insurance exchange, and student health insurance coverage. Additionally, grandfathered health plans, grandmothered health plans, transitional plans and indemnity plans must comply with these final rules. (Grandmothered plans are individual and small-group health plans that took effect after the signing of the Affordable Care Act in March 2010.)

These rules do not apply to health reimbursement arrangements, other account-based plans that tie reimbursement to a maximum fixed dollar amount, excepted benefits plans, short-term limited-duration insurance plans, and retiree-only plans. Additionally, the benefit design of indemnity plans may make certain provisions irrelevant (e.g., if a plan does not have a network of participating facilities, requirements specific to balance billing for non-emergency services furnished by nonparticipating providers at participating facilities would be moot).

Emergency Services

This IFC defines emergency services as generally consistent with the Emergency Medical Treatment and Labor Act (EMTALA), including appropriate medical screening examinations and

any such further examination and treatment required to stabilize the individual, as well as services provided after admitting a patient to the hospital. The Departments broadened the definition of emergency services to include such services when provided by a freestanding emergency department, and include services provided after stabilization unless certain conditions are met (see Notice and Consent section below). Further, this IFC establishes a ban on balance billing for emergency services furnished by out-of-network providers at both out-of-network and in-network facilities.

The Departments also use this IFC to reiterate requirements under the Prudent Layperson Standard established by the Affordable Care Act (ACA). The Departments indicate they are aware of recent actions by some commercial health plans to restrict coverage for emergency services, and unequivocally state that such policies are inconsistent with the requirements of the No Surprises Act as well as the Prudent Layperson Standard. Payers cannot require prior authorization, nor can they limit coverage for emergency services to certain diagnosis codes.

Post-Stabilization Services

Post-stabilization services are subject to balance billing protections until the point of discharge, patient transfer, or receipt of signed consent from the patient to balance bill. In order to balance bill patients for post-stabilization services, providers must meet the following conditions:

- Deem the patient fit for transfer, meaning the patient can travel to a reasonably close in-network facility using non-medical or non-emergency medical transportation. The attending physician or treating provider must make this determination, while accounting for certain socioeconomic factors such as the patient’s access to transportation.
- Obtain the patient’s consent for out-of-network care and permission to balance bill. The attending physician or treating provider must determine whether the patient or their representative is fit to provide such consent, accounting for factors such as the patient’s mental or emotional state, substance use, language barriers, and historical inequities.
- The provider or facility must satisfy any other conditions determined by the Departments in future regulations.
- The provider or facility must comply with any relevant state law, including state laws that prohibit patients from waiving balance-billing protections.

The decision made by the attending physician or treating provider is binding on the facility. The Departments seek comments on whether additional factors and conditions should be included in determining whether a patient is fit for transfer or to consent to balance billing for post-stabilization services.

Ancillary Services

The No Surprises Act also establishes balance billing protections for certain professional or ancillary services furnished by out-of-network providers at in-network facilities. These include:

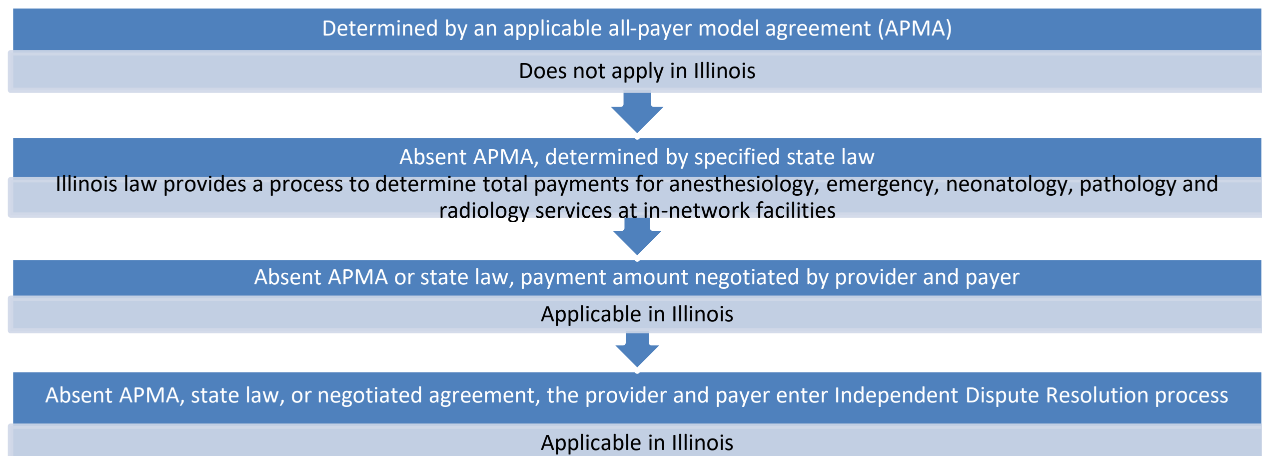
- Anesthesia, neonatology, pathology and radiology services;
- Items and services furnished by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services;
- Equipment, devices, telemedicine services, and pre-and-post operative services in coordination with non-emergency, scheduled services furnished at in-network facilities;
- Items or services provided by an out-of-network provider if there are no in-network providers available; and
- Items or services that result from unforeseen, urgent medical needs that arise during a scheduled procedure for which the patient gave consent to balance bill.

The ability to seek a patient's consent to balance bill is limited to certain services (see Notice and Consent section below). The No Surprises Act's balance billing protections do not apply to non-emergency services furnished at out-of-network facilities.

Determining Out-of-Network Payments

Provider Payments for Out-of-Network Services

The IFC outlines the process for determining the total payment for out-of-network providers furnishing items or services protected under the No Surprises Act. The total payment, inclusive of patient cost sharing, is determined as follows:



If the cost-sharing amount is less than the total payment amount, then the plan must make up the difference, even if the patient has not satisfied their deductible.

Interim Payment (or Notice of Denial) to Providers

Payers have 30 calendar days to make an initial payment to a provider/facility or issue a notice of denial. The 30-day period begins when the payer receives a "clean claim." The Departments do not expect the initial payment to represent a first installment; rather, the payment should be an amount that the payer intends to be payment-in-full.

The Departments did not establish a minimum payment amount, and seek comment on whether they should established a minimum payment amount in regulations.

The Departments listed several options under consideration for a minimum payment rate, including but not limited to:

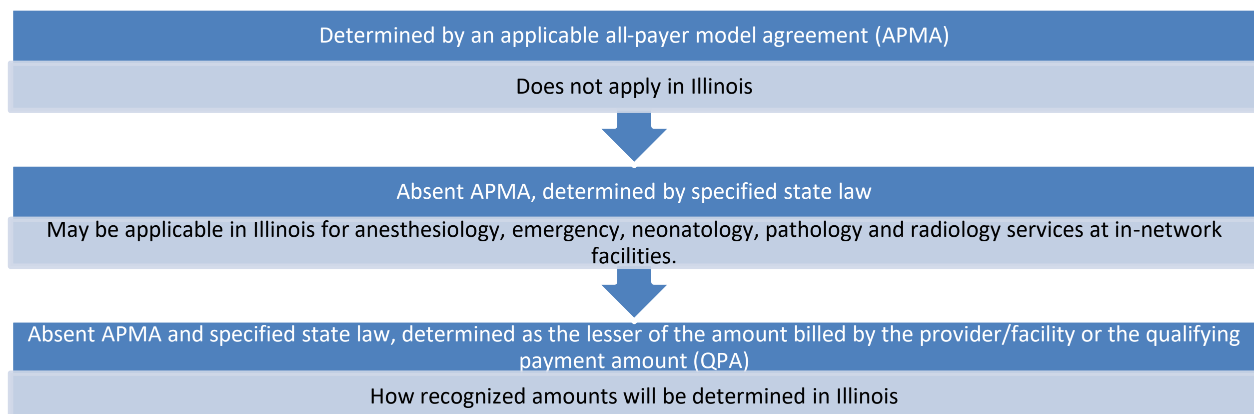
- A specific percentage of the Medicare rate for an item or service;
- A specific percentage of the payer's qualifying payment amount (QPA) for the item or service;
- An amount calculated in the same way the payer typically calculates payment for the specific item or service to out-of-network providers or facilities;
- An amount representing the highest amount that would result from applying two or more of these or other methodologies;
- Any other method; or
- A "commercially reasonable rate" without requiring a specific methodology.

The Departments also seek comment on the impact this process for calculating and providing an initial payment may have on underserved and rural communities, particularly those facing a shortage of providers.

This IFC does not address the independent dispute resolution process established under the No Surprises Act. Additionally, the Departments acknowledge that the timelines outlined in this IFC may not align with existing appeals processes, including those under ERISA. Beginning Jan 1, 2022, payers may adhere to the timelines established by these regulations and the Departments note this may give payers up to 15 additional days to make a determination on a claim compared with current rules. Additionally, providers will use the independent dispute resolution process to challenge denied claims except in cases when the challenge is specific to an adverse benefit determination for which an appeals process already exists.

Patient Cost Sharing for Services Covered under the No Surprises Act

Patient cost sharing is generally limited to the in-network cost-sharing amount. The out-of-network provider must file a claim with the payer to determine the cost-sharing amount, and cost sharing must count toward any applicable in-network deductibles or out-of-pocket maximums. The IFC outlines a process for payers to follow when calculating patient cost sharing based on the "recognized amount," which is determined as follows:



Additionally, when using the QPA to determine patient cost sharing, the IFC stipulated that cost sharing for items and services protected from balance billing is the lesser of the QPA or the billed charges.

Should the patient consent to waiving balancing billing protections, the provider must notify the payer. In such cases, the payer's rules for out-of-network care dictates the patient's cost-sharing amount.

The process to determine patient cost sharing for air ambulance services is based on the lesser of the billed amount or the qualify payment amount. The Airline Deregulation Act of 1978 preempts state laws that relate to air ambulance providers, so there would not be any payments specified by an APMA or in state law.

Calculating the Qualifying Payment Amount (QPA)

Generally, the QPA is the median of contracted rates as of Jan. 31, 2019 for the same or similar item or services, furnished by a provider in the same or similar specialty located in the same geographic region, trended forward using the consumer price index for all urban consumers (CPI-U). The median contracted rate accounts for all group health plans of the plan sponsor, or rates across all group or individual health insurance plans offered by the issuer that are offered in the same insurance market (individual, small group, or large group market, irrespective of the state). Each negotiated contract amount is treated as a separate amount in calculating the median, even if two or more separate contracts pay the same rate. The contracted rate is inclusive of cost sharing, and ad-hoc, single case, or letter of agreement rates should not factor into the median contracted rate calculation.

To assist with the calculation of the QPA, the Departments provided the following definitions:

- Median Contracted Rate: the middle number when contracted rates across all plans offered by a sponsor or issuer in the same insurance market are lined up from lowest rate to highest rate. There must be at three rates available to calculate the median.
- Contracted Rate: the total amount, inclusive of cost sharing, that a payer contractually agreed to pay a provider, including through a third-party administrator or pharmacy benefit manager. Each contracted rate is counted separately.
- Insurance Market: the individual market, small group market, or large group market. For self-insured plans, insurance market means all self-insured group health plans of the plan sponsor or all self-insured group health plans administered by the same entity. Payers should exclude rates for Medicare, Medicaid, short-term, limited duration, account-based plans, and other forms of limited coverage.
- Same or Similar Item or Service: a healthcare item or service billed under the same service code, or under a comparable service code from a different procedural code system. Payers must account for modifiers that affect payment rates and calculate separate median contracted rates for providers and facilities.

- Same or Similar Provider Specialty: the practice specialty of the provider. Payers only need to account for the provider specialty if they contract for a service at different rates based on the provider's specialty. In such cases, payers should calculate separate QPAs by specialty. For air ambulance services, all providers are considered as a single provider specialty regardless of the aircraft type, or whether the air ambulance is hospital-based or independent.
- Same or Similar Facility Type: When payers contract at different rates for emergency services based on the type of facility (hospital-based emergency department versus independent freestanding emergency departments), the payer must calculate separate QPAs for those services. Other facility characteristics are considered irrelevant when calculating QPAs (e.g., patient cost sharing should not vary between an academic medical center versus a non-teaching acute care hospital).
- Geographic Regions: payers should only include rates from the same geographic region, as determined by metropolitan statistical areas (MSAs). The portions of a state that do not fall into an MSA combine to create a single alternative region. The IFC outlines contingencies for cases when there are not enough contracted rates within an MSA. For air ambulances, the region is determined based on where the patient is picked up, and geographic regions are determined at the state level (all MSAs are combined into one region, and all other areas of the state are a second region).

The Departments outlined additional QPA methodologies for alternative payment model contracts (i.e., not fee-for-service), special rules for unit based services (i.e., anesthesia and air ambulances), and methodological contingencies when there are insufficient contractual data to calculate a median, including new items or service codes.

Required Health Plan Information Sharing to Providers

The Departments specified information that payers must share with out-of-network providers regarding the QPA calculation. Specifically, payers must provide a written or electronic statement that includes the following:

- The QPA value for each furnished item and service;
- A statement that the QPA is the recognized amount for determining patient cost sharing;
- A statement indicating each QPA was determined in compliance with the methodologies outlined in the IFC;
- A statement that the provider may enter into a 30-day open negotiation period with the payer, as well as contact information for the appropriate person or office with which to initiate such negotiations; and
- A statement indicating that should negotiations fail, the provider may initiate the IDR process within 4 days of the conclusion of the open negotiation period.

Upon provider request, the payer must disclose additional methodological details regarding the calculation of the QPA for specific items or services. Additionally, upon request and as applicable, the payer must provide a statement that the utilized contracted rates include risk sharing, bonuses, penalties, or other incentive-based or retrospective payments, or adjustments for the items and services involved that were specifically excluded for the purposes of calculating the QPA. The Departments believe that having this information will better inform the open negotiation and IDR processes.

The No Surprises Act requires the Departments to establish a process to audit payers to ensure compliance with QPA requirements, and the Departments indicated they will rely on existing oversight mechanisms at the state and federal levels. Additional rulemaking from HHS will incorporate these requirements into enforcement regulations.

Notice and Consent Process

Patients may waive balance-billing protections under certain circumstances, including for post-stabilization services that meet certain criteria and when the patient chooses to schedule an appointment with an out-of-network provider at an in-network facility. In such cases, the out-of-network provider must use the notice and consent process outlined under the No Surprises Act and this IFC.

Providers cannot use notice and consent for the following services:

- Anesthesia, emergency, neonatology, pathology and radiology services;
- Items and services furnished by assistant surgeons, hospitalists, and intensivists;
- Diagnostic services, including radiology and laboratory services;
- Equipment, devices, telemedicine services, and pre-and-post operative services in coordination with non-emergency, scheduled services furnished at in-network facilities;
- Items or services provided by an out-of-network provider if there are no in-network providers available;
- Items or services the result from unforeseen, urgent medical needs that arise during a scheduled procedure for which the patient gave consent to balance bill.

The Departments note that given this list of exceptions, they expect the notice and consent process will rarely be used. Additionally, the Departments seek comments on whether they should expand the list of excluded ancillary services.

If a patient (or the patient’s authorized representative) does not provide, or revokes, their consent to waive balance billing protections, then the balance billing protections outlined by the No Surprise Act and this IFC remain in place (the patient must revoke consent in writing before items or services are furnished). A provider or facility may refuse to treat the individual if they do not consent, so long as such refusal does not violate other state or federal laws (e.g. EMTALA).

The notice and consent process utilizes a *standard notice document* furnished by HHS. Providers must make notice and consent documents available in the 15 most common language spoken in their geographic region, and if a patient cannot understand one of those languages then the provider must furnish the individual with a qualified interpreter. Auxiliary aids and services should also be available, including large print materials, accessible information and communication technology, open and closed captioning, and other aids or services for persons who are blind, have low vision, are deaf, are hard of hearing, or have other disabilities that require accessibility considerations.

The notice and consent documents should be together when delivered to the patient, and they must be physically separate from any other documents. The Departments established timing requirements for notice and consent to ensure patients have adequate time to review and consider their options. The timing requirements are as follows:

Scheduled Appointment	Notice and Consent Timing
72+ hours	72 hours before appointment
Within 72 hours	On date appointment is made
Same day	3 hours before appointment

The notice must state that the provider furnishing the items or services is an out-of-network provider, include a good faith estimate of what the out-of-network provider may charge, and describe any prior authorization or other care management limitations that may be required in advance of receiving items or services. The good faith estimate must include any item or service that the out-of-network provider reasonably expects to provide in conjunction with the primary item or service. Should the item or service require care from multiple out-of-network providers, the notice must list each provider's name and a good faith estimate for the items and services each provider plans to furnish. The patient must be able to consent to waiving balance billing protections for each individual provider separately.

The notice must clearly state that the patient is not required to consent to receiving the relevant items and services from an out-of-network provider or at an out-of-network facility. Additionally, in cases where out-of-network providers at an in-network facility furnish post-stabilization services, the notice must include a list of any in-network providers at the facility who are able to furnish the same items or services.

Consent must be voluntary, and providers should use the *standard consent document* specified by HHS. The consent notice must state that payment made by the individual might not accrue toward any plan limitation on cost sharing, and that signed consent means the individual agrees to be treated by the out-of-network provider and understands that they are waiving balance billing and cost sharing protections. The patient must receive a copy of the signed notice via a method of their choosing (in-person, mail, or email), and consent does not constitute a contractual agreement regarding treatment or the estimated charge amount.

Out-of-network providers and facilities are responsible for notifying a patient's health plan or plan issuer as to whether balance billing and in-network cost sharing protections apply, and

must provide the payer with a signed copy of the notice and consent (if applicable). Providers must retain written notice and consent documents for at least seven years, and there is not a statute of limitations on submitting a complaint.

Disclosure Requirements

Beginning Jan. 1, 2022, providers and payers must disclose balance-billing protections to patients. Providers must disclose balance-billing protections in three ways:

1. In a prominent, public area of the facility;
2. On the provider's public website; and
3. Directly to the patient via a one-page summary either when billing the patient or when the provider bills the patient's health plan.

The disclosure must include, in plain language, a clear statement on balance billing prohibitions in cases of emergency services and non-emergency services performed by an out-of-network provider at an in-network facility. Providers must also disclose any applicable state law requirements, and include clear contact information for the appropriate state and federal agencies should an individual wish to file a complaint for noncompliance. Disclosures must comply with applicable federal civil rights laws, including reasonable steps to provide meaningful access for individuals with limited English proficiency and appropriate steps to ensure effective communication with individuals with disabilities.

Facilities may provide disclosures on behalf of out-of-network providers if both the provider and facility agree to such an arrangement via an existing or amended contract or written agreement. The Departments provide a *model disclosure notice*; the Departments will consider providers and facilities using this form to be in good faith compliance with this disclosure requirement.

Complaint Process

The IFC outlines a single complaint process that all stakeholders will use to submit oral or written complaints. The Departments will have 60 days to respond to complaints, and may seek additional information from any of the entities involved. Responses may include next steps such as referring the complainant to another appropriate state or federal resolution process or regulatory authority, or initiating an investigation for enforcement action. There is not a statute of limitations on submitting a complaint. Further guidance on the complaint process is forthcoming, and the Departments seek comments on the following:

- Whether the complaint process should be limited to QPA complaints, or should extend to all consumer protections and balance billing requirements;
- What information to require for filed complaints;
- Whether there should be a statute of limitations for filing complaints;
- Whether the individual submitting the complaint should receive notification of the outcome and in what timeframe; and

- Details on how the complaint system should operate, what consumer protections should be established, the user experience, and how to support consumer awareness of the complaint system.

Provider Choice

The No Surprises Act extends patient protections established under the Affordable Care Act to grandfathered plans beginning on or after Jan. 1, 2022. Specifically, these patient protections require coverage of emergency services without prior authorization or requiring the provider be in-network. They also ensure choice when it comes to selecting a health care provider, ensuring access to obstetrical, gynecological, and pediatric care for patients seeking to have these providers as their primary care physician.

Costs

The Departments provide a variety of estimated costs to providers, payers and individuals regarding the implementation of this IFC. Specific to providers, the Departments estimate the following:

- $117.2 million in 2021 to revise standard operating procedures and provide training to staff (average of $6,894 per facility).
- $22.6 million in 2021 (average of $1,330 per facility) and ongoing costs of $117.2 million annually (average of $6,894 per facility) for out-of-network providers and out-of-network emergency facilities to comply with requirements related to notice and consent, recordkeeping, and notice to plans and issuers.
- $6.8 million (average of $400 per facility) in 2021 and ongoing costs of $2.5 million annually (average of $147 per facility) to furnish disclosures on patient protections against balance billing.
- $6.4 million in 2021 to enter into agreements for facilities to provide disclosure on patient protections on behalf of providers (will not apply to all facilities).
- $97,452 annually for individuals and providers to submit complaints related to surprise bills (will not apply to all facilities).

The Departments will issue regulations governing additional provisions of the No Surprises Act in the coming months. IHA will issue comments to the Departments on this IFC, and we encourage member hospitals and health systems to submit comments as well. Questions regarding this summary may be *directed to IHA*.