Issue Brief

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Requirements Related to Surprise Billing; Part II

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.

A copy of the 520-page rule is currently available at: https://public-inspection.federalregister.gov/2021-21441.pdf. The rule is scheduled to be published in the October 7 Federal Register. A 60-day comment period is provided.

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: https://www.cms.gov/nosurprises/Help-resolve-payment-disputes.

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.

COMMENT

This is a complex rule because it involves three Departments (HHS, Labor and Treasury) and the Office of Personnel Management. Each has established its own rulemaking. Together the actual regulatory text extends some 182 pages, 35 percent of the entire document.

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Further, the material contains extensive discussions on the economic impact and paperwork burden totaling another 127 pages, nearly 25 percent of the rule.

The rule states that the "Departments are unable to quantify all benefits, costs, and transfers of these interim final rules but have sought, where possible, to describe these non-quantified impacts." The effects in Table 1 reflect non-quantified impacts and estimated direct monetary costs resulting from the provisions of these interim final rules.

TABLE 1: Accounting Statement

Benefits:

Non-quantified benefits of the Federal IDR process for the population with health coverage:

- Increased protection for participants, beneficiaries, and enrollees from surprise bills from out-of-network providers by creating a process for plans, issuers, FEHB carriers, and nonparticipating providers and facilities to resolve disputes regarding certain out-of-network rates. Note that, unless specified otherwise, providers include providers of air ambulance services.
- Increased awareness of expected charges for items or services, reduction in financial anxiety and out-of-pocket expenses for individuals with health coverage because individuals will be able to meet their deductibles and out-of-pocket maximum limits sooner.
- Increased access to care for individuals with health coverage that may have otherwise forgone or delayed needed treatment due to concerns over the potential for high out-of-pocket expenses.
- Non-quantified benefits of the patient-provider dispute resolution process for uninsured (or self-pay) individuals:
- Increased awareness of expected charges for items or services, reduction in financial anxiety, more informed health care decisions, and protection for uninsured (or self-pay) individuals by requiring providers and facilities to furnish good faith estimates for scheduled or requested items and services.
- Improved access to care for uninsured (or self-pay) individuals that may have otherwise forgone or delayed needed treatment due to concerns over receiving unexpected large bills.
- Protection for uninsured (or self-pay) individuals from excessive surprise bills from providers or facilities by establishing a patient-provider dispute resolution process that may result in lower payments if the SDR entity determines the amount to be paid by the uninsured (or self-pay) individual to the provider or facility are lower than the billed charges.

Non-quantified benefits regarding external review:

- Increased access to benefits for some individuals.
- Reduced incidence of excessive delays and inappropriate denials, averting serious, avoidable lapses in access to quality health care and resultant injuries and losses to participants, beneficiaries, enrollees, and FEHB covered individuals.
- Potential increase in confidence and satisfaction among participants, beneficiaries, and enrollees in their health care benefits.
- Improved awareness among plans, issuers, and FEHB carriers of participant, beneficiary, enrollee, FEHB covered individuals, and provider concerns.

Costs to Plans, Issuers and FEHB Carriers:

Costs (in Millions)	Estimate	Year Dollar	Discount Rate	Period Covered
Annualized Monetized ($/Year	$517.12	2021	7 Percent	2022-2031
	$491.44	2021	3 Percent	2022-2031

The annualized cost estimates reflect estimated costs associated with the Federal IDR process for nonparticipating providers or nonparticipating emergency facilities, the Federal IDR process for providers of air ambulance services, IDR entity certification and reporting requirements, the Federal IDR process for the uninsured, SDR entity certification, and the extension of the external review to grandfathered plans and claims under certain provisions of the No Surprises Act. The Departments estimate a total cost of $760.95 million in the first year and $440.67 million going forward.

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Costs to the Government:
The Federal Government will incur costs to build and maintain the Federal IDR portal and to implement and administer the patient-provider dispute resolution process. The maintenance costs for the Federal IDR portal are split between the Federal IDR process and the patient-provider dispute resolution process, based on anticipated volume for each program. The costs associated with the Federal IDR portal are estimated to be a one-time cost of $6 million in fiscal year 2021 and annual costs of $1 million going forward. The costs associated with the patient provider dispute resolution process are estimated to be a one-time cost of $10 million in fiscal year 2021 and an annual cost of $12 million going forward. Additionally, the costs associated with the Federal external review costs are estimated to be $1.16 million in fiscal year 2021 and $567,000 annually going forward.
Transfers:
Non-quantified transfers associated with the Federal IDR process for the population with health coverage: • Potential transfers from providers who had previously balance billed for out-of-network claims to individuals who are no longer responsible for paying these balance bills. • Potential transfers from plans, issuers, and FEHB carriers who were previously not responsible for out-of-network balance bills to providers and facilities that will submit out-of-network balance bills to plans, issuers, and FEHB carriers as a result of the interim final rules. • Potential transfers from plans, issuers, and FEHB carriers to participants, enrollees, and beneficiaries if the Federal IDR process results in lower premiums. • Potential transfers from participants, enrollees, and beneficiaries to plans, issuers, and FEHB carriers if the Federal IDR process results in higher premiums. • Potential transfers to the Federal Government in the form of reduced Premium Tax Credits if the Federal IDR process results in the lower premiums. • Potential transfers from the Federal Government to eligible enrollees, in the form of increased Premium Tax Credits payments if the Federal IDR process results in an increase in premiums. • Potential transfers from individuals with health coverage who pay premiums to individuals with large out-of-network bills and uninsured individuals if the Federal IDR process results in an increase in premiums. • Potential transfers from providers, facilities, and providers of air ambulance services to plans, issuers, and FEHB carriers if some providers, facilities, and providers of air ambulance services collect lower out-of-network payments. • Potential transfers between providers, facilities, and providers of air ambulance services and individuals with health coverage, depending on the weight place on the qualifying payment amount (QPA) in payment determinations under the Federal IDR process. The presumption in favor of the QPA in the Federal IDR process may result in transfers from providers and facilities to participants, beneficiaries, and enrollees. Non-quantified transfers associated with the patient-provider dispute resolution process for uninsured (or self-pay) individuals: • Potential transfer of the patient-provider dispute resolution administrative fee from the provider or facility to the uninsured (or self-pay) individuals if the SDR entity makes a payment determination in favor of the uninsured (or self-pay) individual. • Potential transfer from uninsured (or self-pay) individuals to providers or facilities if the SDR entity makes a payment determination that is higher than the good faith estimate. Non-quantified transfers associated with external review: • Potential transfer from plans, issuers, and FEHB carriers to participants, beneficiaries, and enrollees now receiving payment for denied benefits.

SUMMARY OF THE RULE

The following is from CMS' fact sheet.

Independent Dispute Resolution

The September 30, 2021 rule establishes the federal independent dispute resolution process that out-of-network (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

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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.
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. Without this additional information, the certified independent dispute resolution entity must select the offer closest to the QPA.

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.

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

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Important Open Negotiation and Independent Dispute Resolution Deadlines	
Independent Dispute Resolution Action	Timeline
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; 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 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.

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Analysis provided for MHA by Larry Goldberg, Goldberg Consulting

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 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.*