



Illinois Health and Hospital Association

No Surprises Act: Hospital Requirements

Cassie Yarbrough, Senior Director, Medicare Policy

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Acronyms

- Affordable Care Act (ACA)
- All Payer Model Agreement (APMA)
- Ambulatory Surgery Center (ASC)
- American Hospital Association (AHA)
- Centers for Medicare & Medicaid Services (CMS)
- Civil Monetary Penalty (CMP)
- Consolidated Appropriations Act, 2021 (CAA)
- Employee Retirement Income Security Act (ERISA)
- Federal Employee Health Benefits (FEHB)
- Illinois Department of Insurance (IDOI)
- Illinois Health and Hospital Association (IHA)
- Independent Dispute Resolution (IDR) Process
- Interim Final Rule with Comment Period (IFC)
- No Surprises Act (NSA)
- Outpatient Prospective Payment System (OPPS)
- Public Health Service Act (PHS)
- Qualifying Payment Amount (QPA)
- Select Dispute Resolution (SDR)
- Senate Bill (SB)
- U.S. Department of Health & Human Services (HHS)
- U.S. Departments of Health & Human Services, Labor and Treasury, the Office of Personnel Management, and the Internal Revenue Service (the Departments)

Learning Objectives

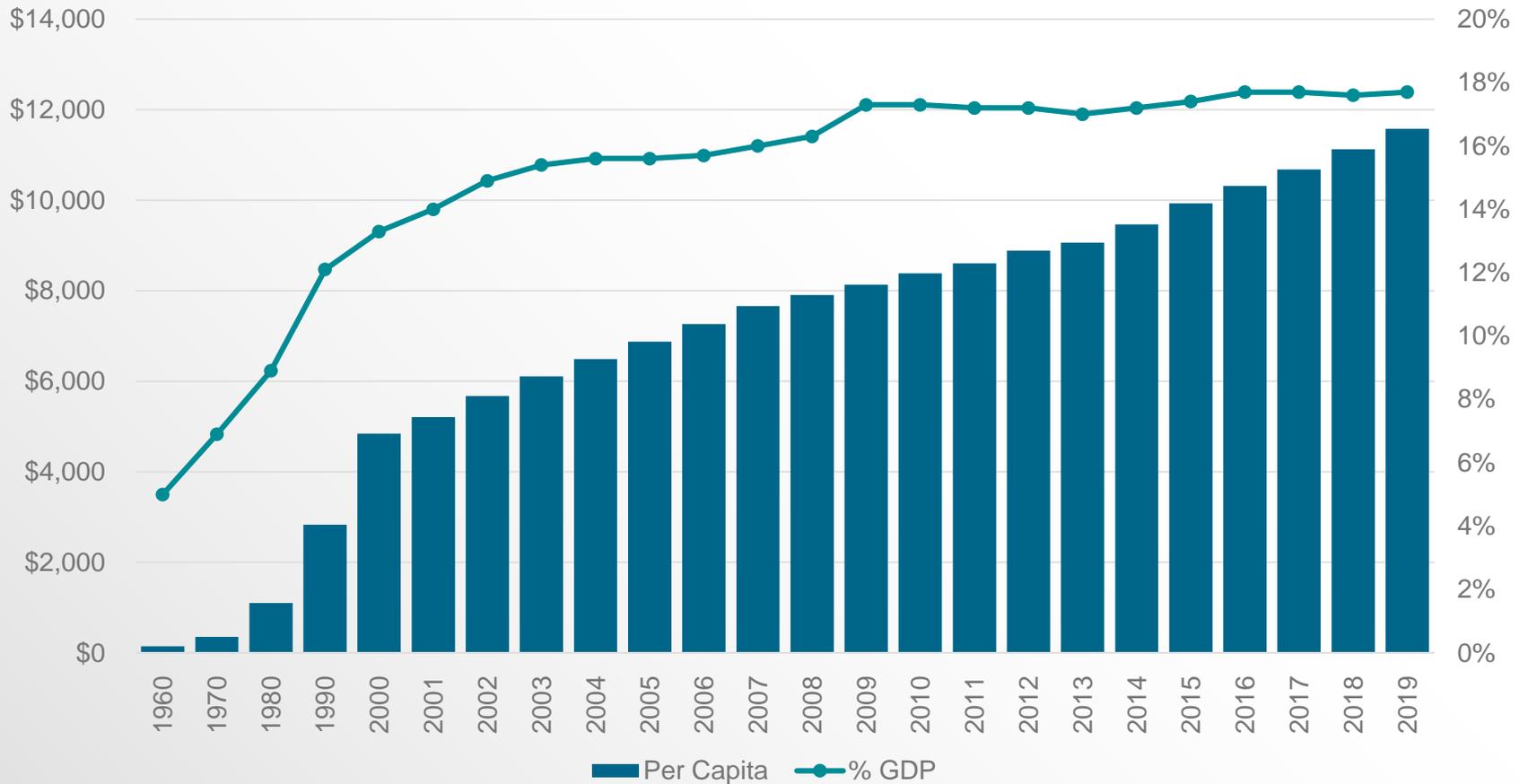
- Outline hospital requirements under the No Surprises Act, including good faith estimates, public disclosures, billing changes, patient waivers and plan/issuer communications
- Describe the provisions of the Illinois Surprise Billing Law (Public Act 096-1523)
- Discuss how these two laws intersect and identify challenges hospitals may face when complying with federal requirements

How We Got Here



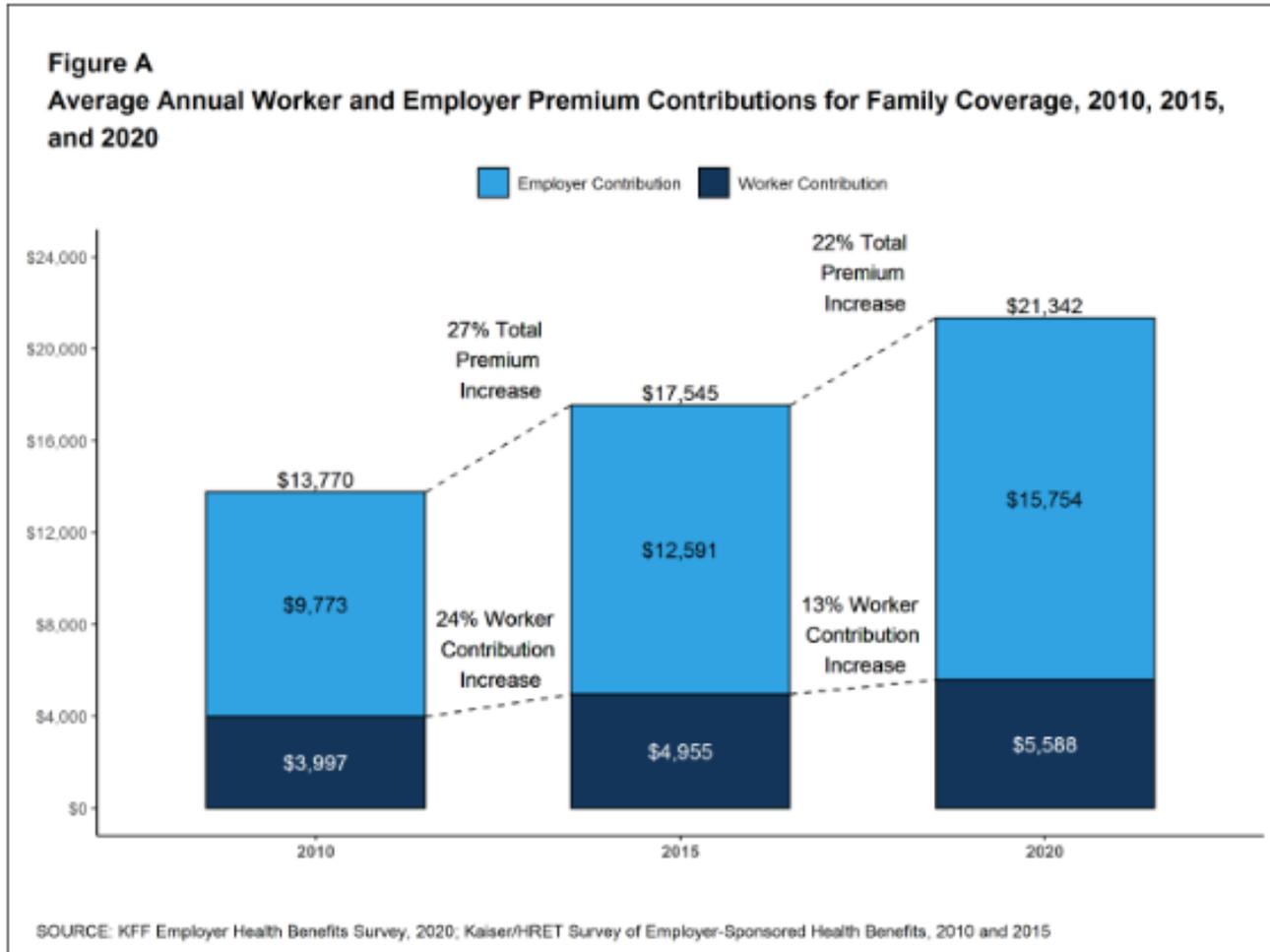
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National Health Expenditures



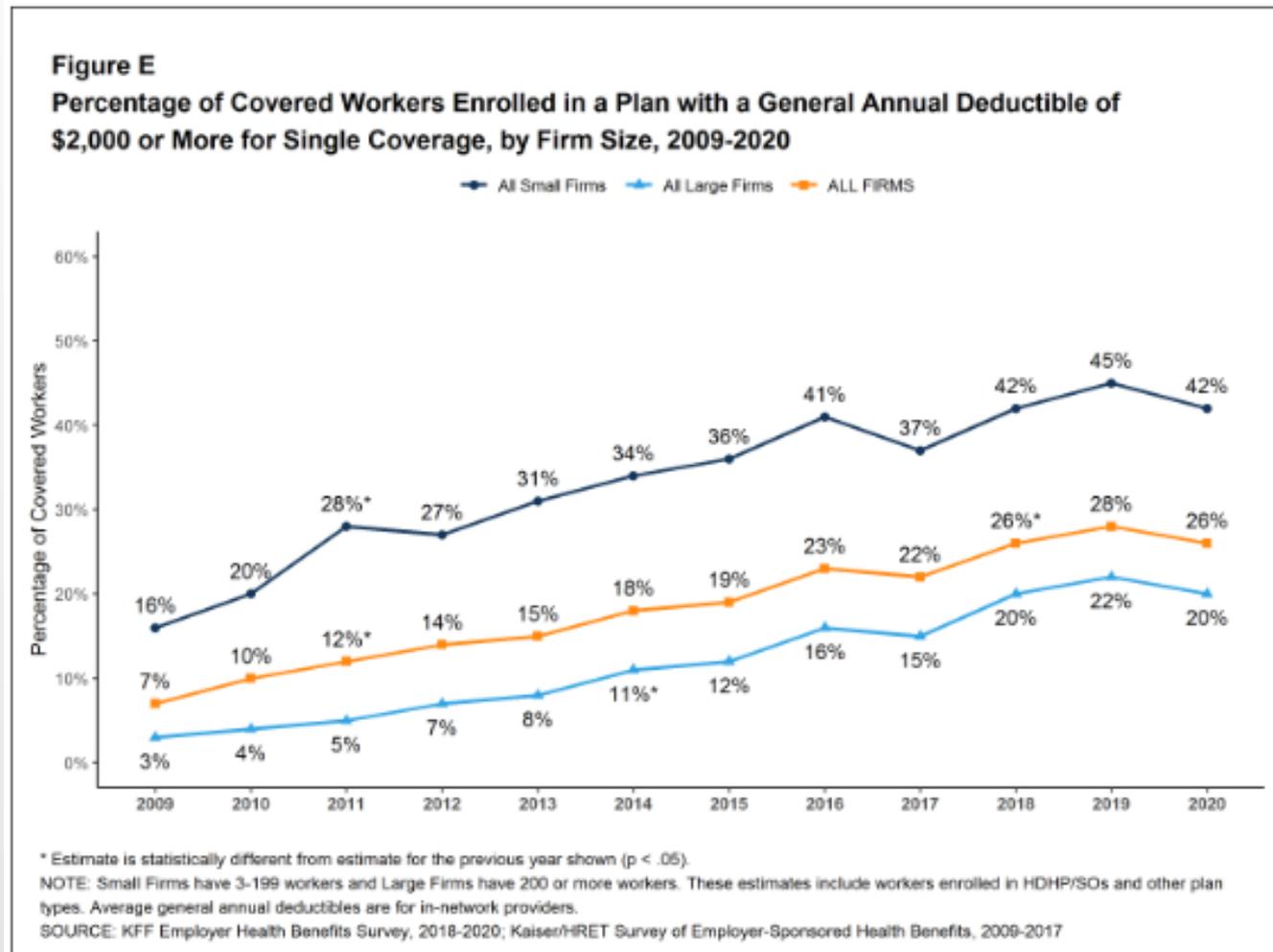
Source: <https://www.cms.gov/Research-Statistics-Data-and-Systems/Statistics-Trends-and-Reports/NationalHealthExpendData/NationalHealthAccountsHistorical>

Premiums Continue to Increase



Source: <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/>

Out-of-Pocket Costs Continue to Rise



Source: <https://www.kff.org/health-costs/report/2020-employer-health-benefits-survey/>

Articulating the Problem

Patients are being asked to act as consumers in a marketplace in which price – a fundamental driver of consumer behavior – is often unknown until after the service they purchase has been performed.

-HFMA Price Transparency Task Force

And The Media Noticed

Susan Sarandon and Cynthia Erivo lend their star power to shine a light on hidden hospital fees in Oscars PSA

By KEVIN KAYHART FOR DAILYMAIL.COM

PUBLISHED: 19:57 EDT, 25 April 2021 | UPDATED: 20:52 EDT, 25 April 2021



NEWS ARTS & LIFE MUSIC PODCASTS & SHOWS SEARCH



SPECIAL SERIES

Bill Of The Month

The Washington Post
Democracy Dies in Darkness

Health

My elderly mom was treated in the ER, recovered and came home. Then the surprise medical bills started coming in.

SHOTS - HEALTH NEWS

Cyclist's Olympic Dream Becomes \$200,000 Medical Bill Nightmare

KAISER HEALTH NEWS

July 29, 2021 • Cyclist Phil Gaimon was competing in a race that could have won him a spot in the Tokyo Olympics. Instead, a crash landed him in two hospitals where his out-of-network surgeries garnered huge bills.

▶ LISTEN · 6:18 + PLAYLIST ⌵ ⏪ ⏹ ⏩

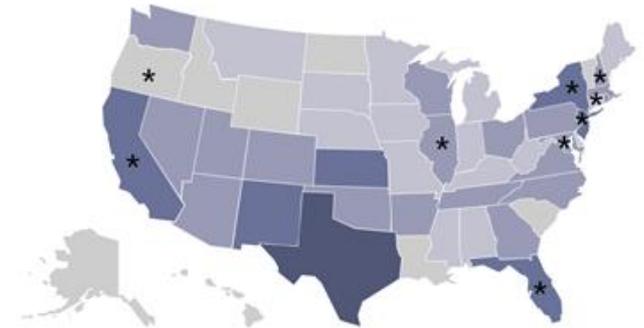


Heidi de Marco/KHN

On Average, 18% of Emergency Department Visits Result in at Least One Surprise Bill, but the Rate Varies by State

Among people with large employer coverage, the share of emergency visits with at least 1 out-of-network charge

● 0-10% ● 11-20% ● 21-30% ● 31% or more
● Insufficient data



* Enacted comprehensive state laws to address surprise bills. However, many private insurance plans can only be regulated at the federal level.
Source: Kaiser Family Foundation

No Surprises Act



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Surprise Billing

When participants receive services from a non-participating (out-of-network) provider and did not have prior knowledge that the provider was a non-participating provider or give prior approval for services provided by a non-participating provider.

-Faegre Drinker

Timeline

- Dec. 27: CAA signed into law
 - Includes the NSA
- July 13: Requirements Related to Surprise Billing; Part 1 (CMS-9909-IFC) published in *FR*
- Aug. 20: the Departments delay enforcement of certain NSA requirements for insured patients
- Sept. 10: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement (CMS-9907-P) published in *FR*
- Oct. 7: Requirements Related to Surprise Billing; Part 2 (CMS-9908-IFC) published in *FR*
- **Effective Date: Jan. 1, 2022**

No Surprises Act

- Protects patients from surprise medical bills when utilizing emergency services, certain services provided by out-of-network clinicians at in-network facilities and air ambulances
- Limits patient cost sharing to in-network amounts
- Establishes negotiation and dispute resolution opportunities for providers and insurers
 - The NSA does not set a benchmark for the IDR process
- Establishes protections for uninsured and self-pay patients, including provision of good faith estimates
- Requires providers and health plans/issuers to help patients access health care cost information

Illinois' Surprise Billing Law

- Public Act 096-1523, in place since 2011
- Provider may not balance bill patient for certain services when:
 - Provided at in-network hospitals or ASCs
 - Patient insured by group or individual plan regulated by the state
 - Note: IL patients protected from balance bills for emergency services at out-of-network facilities as well
- Five Service Categories:
 - Anesthesiology, Emergency, Neonatology, Pathology, Radiology
- Patient faces same out-of-pocket costs as when receiving covered services from an in-network provider

Patient Billing Protections – Effective Jan. 1

- Providers (professionals and facilities) cannot bill out-of-network patients more than the patient's in-network cost-sharing amount for certain services
 - Emergency services, including post-stabilization services until patient is discharged or transferred
 - Scheduled professional services provided at in-network facilities
- Plans/Issuers provide the cost-sharing amount
 - Likely communicated after provider bills the plan/issuer and receives an adjudicated claim

Qualifying Payment Amount (QPA) – Effective Jan. 1

- Determines patient cost-sharing
- Factor for consideration in federal independent dispute resolution (IDR) process
- QPA is the median of contracted rates for a plan/issuer on Jan. 31, 2019:
 - For the same or similar item or service
 - Provided by a provider in the same or similar specialty
 - In the geographic region in which the item or service is furnished
 - Increased for inflation
- Contingency methodologies for new items/services, or in cases of insufficient data

QPA, cont.

- Calculated by the health plan/issuer
- Required information sharing:
 - QPA serving as recognized amount for cost-sharing purposes
 - Value of QPA
 - Statement certifying QPA was calculated consistent with NSA regulations
 - Statement that provider may enter into 30-day open negotiation period with plan/issuer
- For QPA calculation detail, providers must request additional information
- Plan/issuer must send QPA information within 30 days of receiving a clean claim

Patient Cost Sharing based on Recognized Amount – Effective Jan. 1

Determined by an applicable all-payer model agreement (APMA)

Does not apply in Illinois



Absent APMA, determined by specified state law

May be applicable in Illinois for anesthesiology, emergency, neonatology, pathology and radiology services at in-network facilities.



Absent APMA and specified state law, determined as the lesser of the amount billed by the provider/facility or the QPA

Applicable in Illinois (post-stabilization services)

Determining Out-of-Network Payment – Effective Jan. 1

Determined by an applicable all-payer model agreement (APMA)

Does not apply in Illinois



Absent APMA, determined by specified state law

May be applicable in Illinois for anesthesiology, emergency, neonatology, pathology and radiology services at in-network facilities



Absent APMA or state law, payment amount negotiated by provider and plan/issuer

Applicable in Illinois



Absent APMA, state law, or negotiated agreement, the provider and plan/issuer enter Independent Dispute Resolution process

Applicable in Illinois

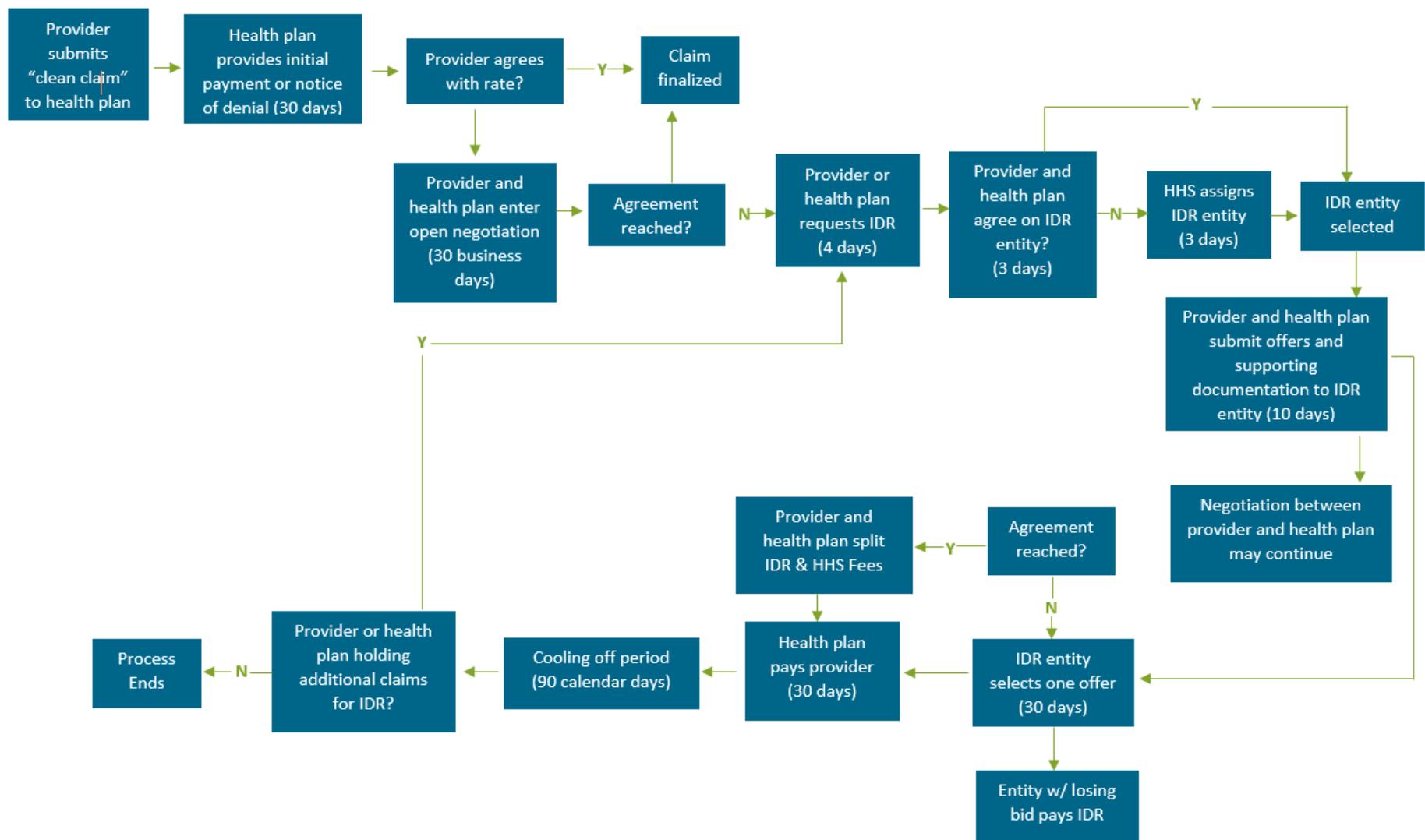
Out-of-Network Payment, cont.

- Initial payment or notice of denial must be made within 30 calendar days of receiving a “clean claim”
- No established requirements related to the amount of the initial payment
- Departments note the initial payment should not be treated as a “first installment,” but rather as payment in full (from plan/issuer’s perspective)
- Plans/issuers may not deny claims for items/services subject to the NSA because the patient does not have out-of-network benefits

Out-of-Network Payment, cont.

- Provider may accept plan/issuer's initial payment
- Provider and plan/issuer may agree to a payment amount through open negotiations
- Provider and plan/issuer may enter into the independent dispute resolution (IDR) process
 - Negotiations may continue during the IDR process, with arbitration ending early if negotiations are successful

Federal IDR Process



Payment Determination

- Assumption is QPA is appropriate payment amount
- IDR entities must also consider additional credible information submitted by plans/issuers and providers
 - Credible: upon critical analysis, the information is worthy of belief and is trustworthy
- Credible information may include:
 - Training, experience, quality and outcomes of provider that furnished the item/service
 - Market share held by provider or plan/issuer
 - Information on patient acuity or complexity of item/service
 - Teaching status, case mix, and scope of services of nonparticipating provider
 - Information about any good faith efforts (or lack thereof) made to enter into network agreements

Additional Payment Details

- Providers may batch like claims for the same health plan occurring during a 30-day period
 - Additional guidance forthcoming
- Party that submits the losing bid must pay IDR costs
 - If parties negotiate payment prior to conclusion of process, parties split incurred costs to that point
 - There are also administrative fees due to HHS

Illinois Arbitration Process



Interaction with PA 096-1573

Scenario		No Surprises Act Applies	IL PA 096-1573 Applies	Both Laws Apply
Patient care occurs in the same state that regulates the provider/facility	State-regulated plan, PA 096-1573 covers all rendered services and has a policy for provider reimbursement	No	Yes	No
	State-regulated plan, PA 096-1573 is not as comprehensive as NSA (e.g. post-stabilization services)	Partial	Partial	Yes
	Federally-regulated plan, has not opted into state law	Yes	No	No
	Federally-regulated plan, opted in to state law that covers full scope of services and includes policy for provider reimbursement	No	Yes	No
	Federally-regulated plan, opted in to state law that is not as comprehensive as NSA	Partial	Partial	Yes
Patient lives in a state with balance billing protections but the out-of-network care is provided in another state without balance billing protections		Yes	No	No
Patient in a state-regulated health plan (or federally regulated health plan that has opted in to state law) that is more expansive than federal law		No	Yes	No

Polling Question

To your knowledge, has your hospital or health system ever participated in Illinois' surprise billing arbitration process?

- Yes, often
- Yes, rarely
- No
- No sure

Notice and Consent – Effective Jan. 1

- Limited opportunity to waive balance billing protections
- Cannot be used for items/services:
 - Related to emergency medicine, anesthesiology, pathology, radiology and neonatology (physician or non-physician practitioner)
 - Delivered due to unforeseen urgent medical needs during a procedure for which patient gave balance billing consent
 - Provided when no in-network practitioner is available
 - Provided by assistant surgeons, hospitalists and intensivists
 - Are diagnostic, including radiology and laboratory services

Notice and Consent, cont.

- Attending ER/treating physician must determine:
 - Patient can be transferred to participating provider using non-emergency or non-medical transportation within a reasonable distance
 - Patient understands notice and can provide informed consent
- Provider/facility satisfies all other notice and consent requirements as determined by the Departments
- Provider/facility complies with any relevant state law

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

Notice and Consent, cont.

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.

Estimate of what you could pay

Patient name: _____

Out-of-network provider(s) or facility name: _____

Total cost estimate of what you may be asked to pay:	_____
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- ▶ **Review your detailed estimate.** See Page 4 for a cost estimate for each item or service you'll get.
- ▶ **Call your health plan.** Your plan may have better information about how much you will be asked to pay. You also can ask about what's covered under your plan and your provider options.
- ▶ **Questions about this notice and estimate?** Call [Enter contact information for a representative of the provider or facility to explain the documents and estimates to the individual, and answer any questions, as necessary.]
- ▶ **Questions about your rights?** Contact [contact information for appropriate federal or state agency]

Prior authorization or other care management limitations

[Enter either the name of the provider or facility that are a limitation on your benefits, or the following information:]

Except in certain instances, we may require you to get prior authorization for certain services before we will pay for them. For more information, visit [website].

Enforcement of good faith estimate delayed for insured patients

[In the case where this notice is being provided for post-stabilization services by a nonparticipating provider within a participating emergency facility, include the language immediately below and enter a list of any participating providers at the facility that are able to furnish the items or services described in this notice]

Understanding your options

You can also get the items or services described in this notice from these providers who are in-network with your health plan:

More information about your rights and protections

Visit [website] for more information about your rights under federal law.

Polling Question

When does your hospital or health system apply relevant discounts for non-emergency items or services rendered to uninsured or self-pay patients?

- Upon scheduling the non-emergency item or service
- After sending the uninsured or self-pay patient an initial bill of charges
- After the patient is approved for financial assistance
- Not sure

Good Faith Estimates for Uninsured/Self-Pay – Effective Jan. 1

- Required for uninsured/self-pay patients that schedule services or request a good faith estimate
 - Self-pay: patients who may have health care coverage but do not have benefits for an item/service under their plan or do not plan to submit a claim to their plan for the scheduled service
- Must be the cash/self-pay rates, reflective of any discounts (e.g., financial aid) for which the patient would be eligible

Timeline

Scheduled services 3-9 days out	No later than 1 business day after the date of scheduling
Scheduled services 10+ days out	No later than 3 business days after the date of scheduling

Good Faith Estimates, cont.

- Include all reasonably expected items/services and related charges from admission to discharge
- Convening provider responsible for delivering estimate to the patient
 - Convening provider: provider/facility responsible for scheduling the primary item/service
- Must also include good faith estimate for co-providers/co-facilities
 - Co-provider/co-facility: any provider/facility providing care to the patient for whom the convening provider does not bill
- The Departments anticipate patients comparing good faith estimates to consumer-friendly shoppable service files on hospital websites

Good Faith Estimate Template

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

[Provider/Facility 1] Estimate

Provider/Facility Name		Provider/Facility Type	
Street Address			
City	State	ZIP Code	
Contact Person	Phone	Email	
National Provider Identifier		Taxpayer Identification Number	

Details of Services and Items for [Provider/Facility 1]

Service/Item	Address where service/item will be provided	Diagnosis Code	Service Code	Quantity	Expected Cost
	[Street, City, State, ZIP]	[ICD code]	[Service Code Type: Service Code Number]		

Total Expected Charges from [Provider/Facility 1] \$

Additional Health Care Provider/Facility Notes

Polling Question

Eventually providers will have to supply good faith estimates of expected charges for furnishing scheduled items or services for insured individuals. This information must go to the individual's plan or coverage. Does your hospital or health system have the technical infrastructure necessary for transmitting such data between your facility and health plans/issuers?

- Yes, and we already do this for some/all insured patients
- Yes, but we do not currently do this
- No
- Not sure

Patient-Provider Dispute Process – Effective Jan. 1

- For uninsured and self-pay patients to dispute total billed charges that are substantially in excess of the total expected charges listed on the good faith estimate
 - Substantially in excess: total billed charges are higher than total expected charges by \$400 or more
- Applies even when excess caused by unforeseen circumstances or when there is a change in co-providers or co-facilities after supplying the good faith estimate
- **Delayed enforcement: HHS will exercise enforcement discretion when the good faith estimate does not include expected charges for items and services from a co-provider/co-facility from Jan. 1, through Dec. 31, 2022**

Payment Determination

- Assumption is good faith estimate is the appropriate payment amount
- Selected dispute resolution (SDR) entity must consider credible information from provider justifying difference between total billed charges and good faith estimate
- Providers may receive less than total billed charges, even when total billed charges are justified

Public Disclosure – Effective Jan. 1

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 balance 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.

if you get other services at these in-network facilities, out-of-network providers **can't** balance bill you, unless you give written consent and give up your protections.

You're never required to give up your protections from balance billing. You also aren't required to get care out-of-network. You can choose a provider or facility in your plan's network.

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

When balance billing isn't allowed, you also have the following protections:

- You are only responsible for paying your share of the cost (like the copayments, coinsurance, and deductibles that you would pay if the provider or facility was in-network). Your health plan will pay out-of-network providers and facilities directly.
- Your health plan generally must:
 - Cover emergency services without requiring you to get approval for services in advance (prior authorization).
 - Cover emergency services by out-of-network providers.
 - Base what you owe the provider or facility (cost-sharing) on what it would pay an in-network provider or facility and show that amount in your explanation of benefits.
 - Count any amount you pay for emergency services or out-of-network services toward your deductible and out-of-pocket limit.

if you believe you've been wrongly billed, you may contact *[applicable contact information for entity responsible for enforcing the federal and/or state balance or surprise billing protection laws]*.

Visit *[website]* for more information about your rights under federal law.
[if applicable, insert: Visit [website] for more information about your rights under [state laws].]

Other Provisions – Effective Jan. 1

Continuity of Care

- 90 days of continued coverage for insured patients when there is a change in their plan's provider network

Provider Directories

- Plans required to establish:
 - A verification process to ensure accurate provider directories;
 - A response protocol for individuals inquiring about the network status of a provider; and
 - A publicly accessible provider database
- Patients relying on inaccurate provider directories only subject to in-network cost-sharing amounts
- **Departments are exercising enforcement discretion**

Enforcement – Effective Jan. 1

- States are primary enforcement authority (CMS backup)
- Enforcement based on complaints, report, and audits
- Single complaint process
 - Oral or written complaints
 - The Departments have 60 days to respond
 - Complaints must identify parties involved and action/inaction subject to complaint; departments may seek additional information
 - No statute of limitations on timeframe for submitting a complaint BUT enforcement action limited to 6 years from alleged violation
 - Complaints may come from consumers, state insurance departments, the National Association of Insurance Commissioners, other federal/state agencies, providers or health plans/issuers
- Provider/Facility CMP: \$10,000/violation

Key Takeaways

- QPA drives payment under the NSA
- Onus on providers to prove payment should be different than the QPA or expected charges
- Mixed reaction to IFC Part 2 from Congress
- Applicability of Illinois' law depends on the provider, items/services, and whether Illinois' arbitration process supersedes federal IDR process (remains unclear)
- Illinois's role enforcing NSA requirements is unclear

Next Steps

This is complex!

- What you can do now:
 - Develop capability for providing good faith estimates
 - Consider how your hospital will incorporate financial assistance into good faith estimates
 - Consider necessary systems changes for compliance
 - Assess current network participation with plans/issuers
 - Develop guidelines for assessing acceptable payments from plans/issuers
 - Develop processes for pursuing IDR
 - Staff education/training
- Rules will evolve with future guidance – ensure organizational flexibility

What IHA is Doing

- Comments on IFC Part 2 due Dec. 6
 - Requesting delayed enforcement
 - Encourage all Member Hospitals and Health Systems to submit comments as well
- Tracking legal action (Texas Medical Society)
- Working with the AHA to make changes and obtain guidance/clarification
- Engaging with Illinois Department of Insurance
- Congressional Delegation Outreach
- Meetings with Members
 - What are you most concerned about?
 - How can IHA help?

Illinois Health and Hospital Association

www.team-iha.org

Cassie Yarbrough

Senior Director

Medicare Policy

cyarbrough@team-iha.org or 630-276-5516



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