AAOS
American Association of Orthopaedic Surgeons

# Surprise Billing Regulations Part I: What Physicians Need to Know

***What?*** The first part of the regulations implementing the No Surprises Act, which was signed into law at the end of 2020, have been released by the Departments of Health and Human Services, Labor, and Treasury. The agencies will issue additional regulations in the coming months to fulfill the directives to ban "surprise" medical bills for out-of-network emergency care. The rule follows more than two years of AAOS advocacy to remove patients from the middle of out-of-network billing disputes and ensure that physicians can access an independent dispute resolution (IDR) process for resolving payment issues as opposed to a federal rate-setting benchmark.

***When?*** The rules will take effect on January 1, 2022. Hospitals, providers, and insurers will all be required to meet new standards for the disclosure of information regarding a patient's insurance status and estimated cost-sharing for non-emergent care.

***How?*** This Part I regulation lays out the following processes and rules for preventing unexpected out-of-network bills for emergent and scheduled care.

## *Emergency Care*

Health insurers will be **required to cover emergency services** without individual patients or health care providers obtaining prior authorization, even when the emergency services are provided out-of-network. The definition of emergency services will include stabilization services, including pre-stabilization services provided prior to admission but outside of the emergency department

Under the rule, independent, freestanding emergency departments will include urgent care centers in the definition so long as they are permitted to provide emergency care under relevant state law. Post-stabilization services will be considered, for the purposes of surprise billing protections, as emergency services unless these criteria are met:

- The attending physician determines that the patient is able to travel using nonmedical transportation to an available, in-network provider or facility that is within a reasonable distance
- The provider or facility providing the post-stabilization services must satisfy the notice and consent criteria
- The patient or patient's representative must be in a condition to receive and under the information in the notice and consent form
- The provider must or facility must satisfy any additional requirements or prohibitions under state law

## *Non-Emergency Services Provided by Nonparticipating Providers at Participating Health Care Facilities*

Unless the provider has met the notice and consent requirement, the **insurer may not impose cost-sharing on the patient** for those items and services that is more expensive than the cost-sharing requirement should those same items and services been provided by an in-network provider. The cost-sharing is calculated as the total amount which would be charges for the items and services by a participating provider, using one of the following:

- An amount set by an applicable All-Payer Model Agreement
- If there is no All-Payer Model Agreement, an amount determined by specified state law;
- If neither of the above are available, then the lesser of the amount billed by the provider or the Qualified Payment Amount (QPA)

QPA is defined as the median of the contracted rates of the plan or issuer for the item or service in the geographic region. Once this amount has been determined and billed to the patient, the provider and insurer will separately determine the total payment for the furnished items and services.

- If the provider and plan cannot agree on a payment amount, the parties may enter into the Independent Dispute Resolution (IDR) process to determine the final amount as determined by the arbiter.
- The parties may enter into arbitration and decide on an agreed amount prior to the arbiter's decision. However, if they do not, then the decision of the arbiter is final.

This Part I rule does not address the mechanics of the IDR process, which will come in a Part II rule. The AAOS will provide an updated fact sheet at that time.

## *Non-Fee-for-Service Contractual Arrangements*

If a QPA must be determined to account for costs of care for non-emergency services provided by nonparticipating providers at participating facilities, but the plan and provider are working within an alternative payment model, such as a bundled payment, the **insurer will be required to calculate the median contracted rate for each item and service using the underlying fee schedule rates.** The underlying fee schedule rate is the rate for the covered item or service from a specific participating provider, providers, or facility that the insurer uses to determine the patient's cost-sharing liability for the item or service, when that is different from the contracted rate.

The calculated median contracted rate will exclude risk sharing, bonus, or penalty, or any other incentive-based and retrospective payments or adjustments.

The QPA for 2022 will be calculated by increasing the median contracted rate by the percentage increase of the consumer price index for all urban consumers over the 2019, 2020, and 2021 increases. The QPA for 2022 will then be adjusted annually for items and services provided in 2023 and subsequent years.

When there is not enough data to determine the QPA (less than three contracted rates as of January 31, 2019 or it is new plan coverage or service codes), the health plan will calculate the QPA by calculating the median contracted rate for the first sufficient information year. This is either:

- The first year after 2022 for which the health plan has sufficient information to calculate the median of the contracted rates from the year immediately preceding that first year after 2022;
- Or, for newly covered items or services, the first year after the first coverage year.

## *Databases Used to Calculate the QPA*

The regulation clarifies that in addition to state all-payer claims databases, **other third-party databases will also be eligible** as long as the following standards are met:

- The database or organization maintaining the database will be prohibited from affiliations with any health insurance issuer, health care provider or facility, or any member of the same controlled group or under common control of any such company.
- The database must have sufficient data to reflecting the in-network amounts paid by health insurers offering group or individual coverage.
- The database must have the capacity to delineate between amounts paid to participating provider and facilities by commercial insurers and those billed by nonparticipating providers, as well as the amounts paid by public payers including Medicare, Medicaid, and CHIP.

For new service codes, the Medicare established payment rate can be used to approximate the relative cost of a new service code compared to the rate billed under an existing, related service code. This will then be multiplied by the QPA for the related service for the year in which the service is provided.

## *QPA Transparency*

**Providers may request the following information from an insurer** with the initial payment of denial of payment:

- The QPA for each item or service

- The insurer must clarify that the QPA applies for purposes only of the recognized amount and that the QPA shared with the provider and/or facility was determined in compliance with this regulation.
- The insurer must inform the provider or facility that they are eligible initiate a 30-day open negotiation period to determine the total payment amount. If the 30 day negotiation ends without agreement, the provider subsequently has 4 days to initiation the IDR process.

Upon request, the provider or facility can also request that the insurer disclose if the QPA includes rates not based on a fee-for-service model, which related service code was used if the disputed payment is for a new service code, and which eligible database was used to calculate the QPA. The provider may also request a disclosure regarding whether the inclusion of risk-sharing, bonus, or penalty was included in the contracted rate calculated to determine the QPA.

## *Initial Payment*

**Insurers are required to send an initial payment or notice of denial not more than 30 calendar days after the nonparticipating provider or facility submits a "clean claim."** Toward that end, providers and facilities should attempt to ensure that information about whether surprise billing protections apply to the claim are included on the form. The initial payment should be the amount the insurer "reasonably intends to be payment in full" based on the case and as required by the plan.

Enforcement of these rules, including the intentional balance billing of patients by out-of-network providers will be addressed in future rulemaking. There will leniency in penalty if the balance billing rules are broken in cases where it would not have been reasonably known by the provider.

## *Notice and Consent*

To prevent surprise bills and ensure that patients can maintain autonomy in choosing any provider they wish, including those who are out-of-network, **the rule requires a notice and consent period**. This applies in the following ways:

- If a patient schedules an appointment at least 72 hours prior to the appointment date, the provider or facility must give notice to the individual no less than 72 hours prior to the appointment. If the appointment is made within the 72 hour window, the notice must be given that day.
- If the patient is provided notice on the same day items and services are provided, the notice must be given no less than 3 hours prior to the furnishing of the items and services.

"If they choose, multiple nonparticipating providers that are furnishing related items and services for an individual may provide a single notice to the individual, provided that:

1. each provider's name is specifically listed on the notice document;
2. each provider includes in the notice a good faith estimate for the items and services they are furnishing, and the notice specifies which provider is providing which items and services within the good faith estimate; and
3. the individual has the option to consent to waive balance billing protections with respect to each provider separately."

A good faith estimate is the amount that the provider and/or facility anticipates they will bill for the items and services. This should also acknowledge potential prior authorization requirements which may come into consideration as it relates to cost estimates. HHS is issuing a model disclosure notice that providers and facilities can use to meet the requirements regarding the patient protections against potential surprise medical bills. The disclosures required can be satisfied for the purpose of the provider, if the facility, such as the emergency department or independent freestanding emergency department, agrees to provide the information.