Surprise Billing Regs – Part 1: QPA, Notice & Consent, Complaint Process, Audits and Air Ambulances

July 2, 2021

The Administration released an Interim Final Rule (IFR) with request for comments to implement part of the "No Surprises Act." The IFR addresses how the patient's cost-sharing obligations are determined, the methodology for determining the qualifying payment amount, the notice and consent requirement providers must adhere to, the process for consumers to file complaints against providers and health plans, how health plans will be audited, as well as the law's application to air ambulances. Additional regulations to address the independent dispute resolution process and any remaining provisions of the law are expected later this year.

The regulations will take effect for health care providers and facilities on January 1, 2022. For group health plans, health insurance issuers, and Federal Employees Health Benefits Program carriers, the provisions will take effect for plan, policy, or contract years beginning on or after January 1, 2022.

Click here for the Interim Final Rule with comment period, here and here for the HHS fact sheets and here for the press release. The comment period is 60 days, from the date the IFR is published in the Federal Register.

Congress passed the "No Surprises Act" as part of the Consolidated Appropriations Act of 2021 (P.L. 116-260) in December. Click here for the law; the No Surprises Act begins on page 1576.

We will continue to review the IFR and provide additional information. This memo serves to direct you to some key provisions.

Highlights

When the health plan covers emergency services, emergency services are to be covered without prior authorization and regardless of whether the provider or facility is in or out of network.

Emergency services include certain services in an ED, as well as post-stabilization services in certain instances (therefore balance billing protections apply).

- Emergency services include pre-stabilization services that are provided after the patient is moved out of the ED and admitted to a hospital. (page 28).

- Post-stabilization services are included in emergency services (and balance billing protections apply) unless the provider determines the patient is able to travel using non-medical transportation or nonemergency medical transportation to a participating provider or facility located within a reasonable travel condition, taking into consideration the individual's medical condition. Providers are to assess and factor in certain social risk factors, such as the patient's ability to pay for the cost of travel. The Departments are asking for comment on how to define reasonable travel distance.
- Providers must then provide notice and consent and the patient (or his or her representative) must be in a condition to receive notice and voluntarily give consent.
- Providers must then comply with any applicable state law provisions. (The discussion on pages 28-38 is important to read)

Patient cost sharing for out-of-network services subject to the rule is limited to no higher than in-network levels. Cost sharing amounts are calculated based on

- All-payer model agreement if applicable
- Amount determined under state law if applicable
- If neither of the above apply, the lesser amount of either the billed charge or the QPA, which is generally the plan's median contracted rate

The out of network rate to be paid to provider or facility is based on

- All-payer model agreement if applicable
- Amount determined under state law if applicable
- Amount agreed upon by plan or issuer and provider or facility
- If none of those three apply, amount determined by IDR entity (regulations to implement this process are forthcoming)

Discussion of Key Provisions

How the federal requirements interact with states that have surprise billing laws - see discussion beginning on page 49. Note specific request for comments on page 52.

Methodology for determining the Qualifying Payment Amount – see discussion beginning on page 62

Treatment of Alternative Payment Models – see page 79

For the limited information plans are to share with providers regarding how the QPA is determined – see page 99

HHS proposes to use its existing programs to audit health plans' compliance – see page 102

For the determination of the out-of-network rate in absence of state law or an all-payer method – see page 103

Consumer complaints process against plans and providers – see page 111

For notice and consent requirements providers must adhere to – see page 124

- Standards for consent – see page 134
- Exceptions to availability of consent – see page 143
- For requirements to notify insurers - see page 146

Provider and facility disclosure requirements – one page notice publicly available - see page 148

Definition of health care facility – see page 209

Text of the IFR – Begins on page 264

Sections of the regulations are generally applicable to group health plans and health issuers for plan and policy years beginning on or after 1/1/22. The HHS-only regulations that apply to health care providers, facilities and providers of air ambulance services are applicable beginning on 1/1/22. The OPM-only regulations that apply to carriers under the FEHB program are applicable to contract years beginning on or after 1/1/22. Below are references for each program:

- Methodology for calculation of median contracted rate – page 278, page 326, page 373
- Methodology for calculation of qualifying payment amount – page 288, page 320, page 328, page 367, page 375
- Information to be shared about qualifying payment amount – page 296, page 336, page 383
- Definition of emergency medical condition – page 277, page 317, page 362
- Notice and consent – page 395

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