



Illinois Health and Hospital Association

# No Surprises Act

Cassie Yarbrough, Senior Director, Medicare Policy

March 24, 2022

# 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)
- Federal Register (FR)
- 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

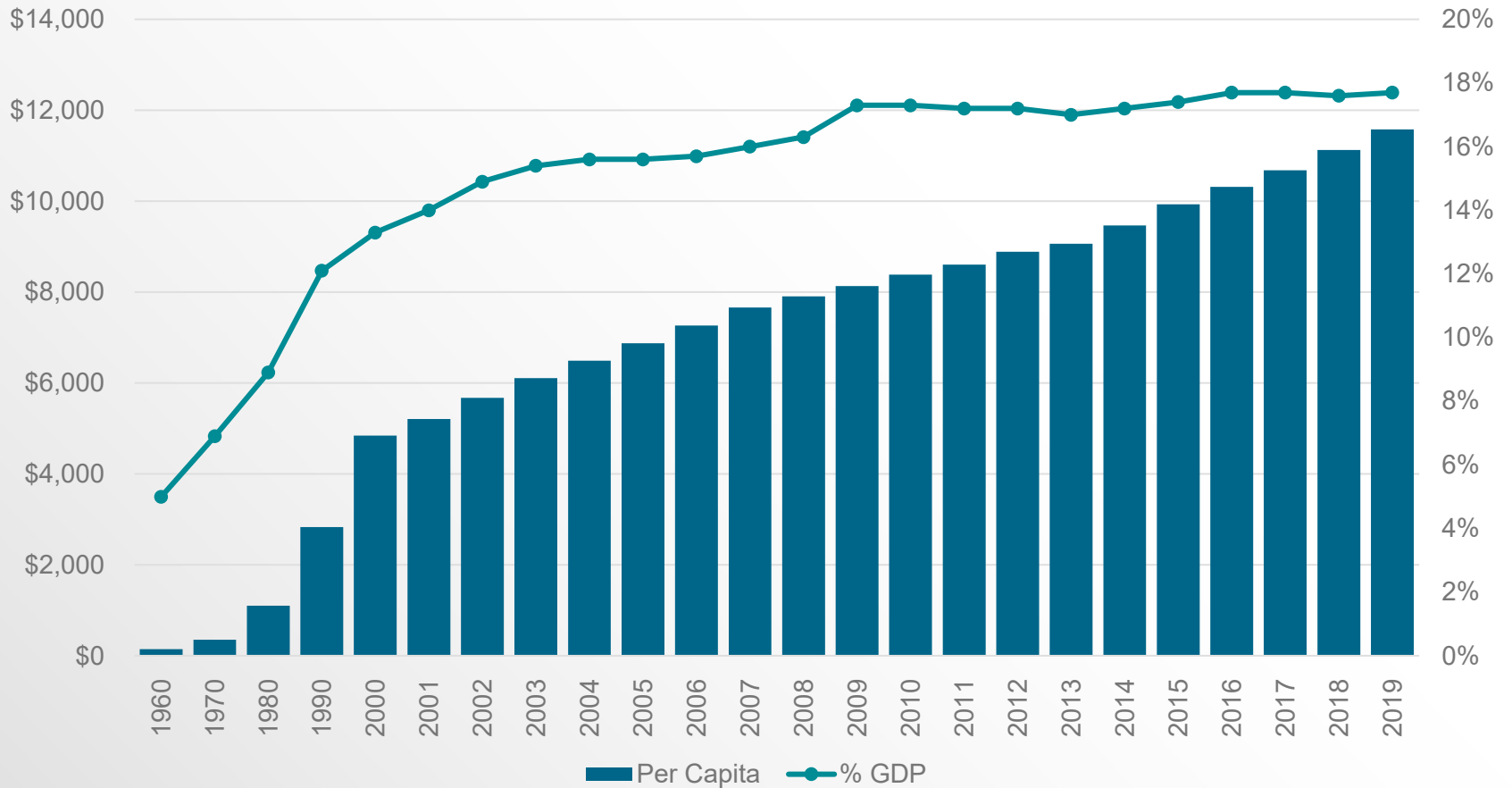
- Outline hospital requirements under the NSA, including good faith estimates, public disclosures, billing changes, patient waivers, and plan/issuer communications
- Describe the provisions of the Illinois Surprise Billing Law (Public Act 096-1523), and how it intersects with federal requirements
- Identify ongoing challenges hospitals may face when complying with federal requirements

# How We Got Here



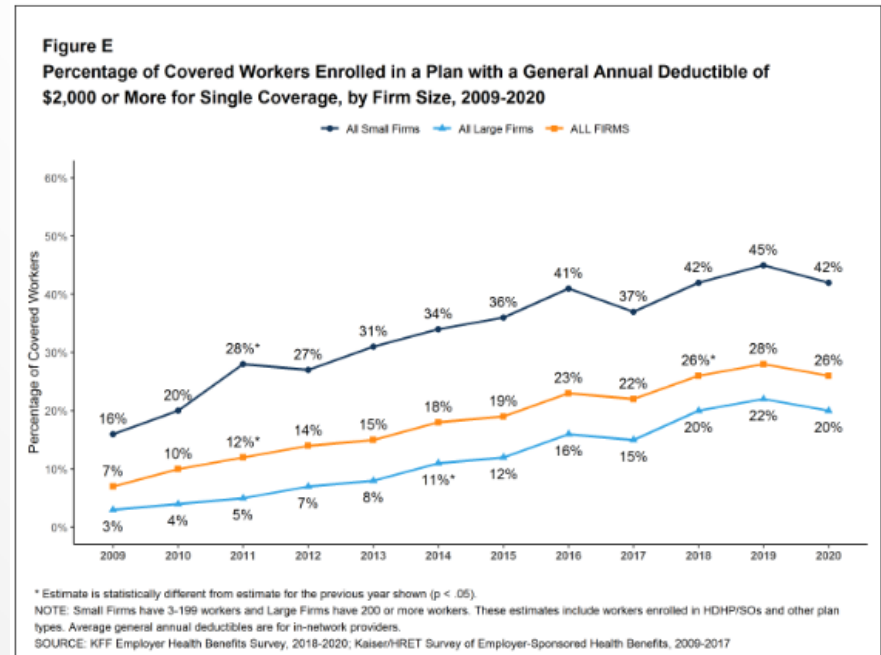
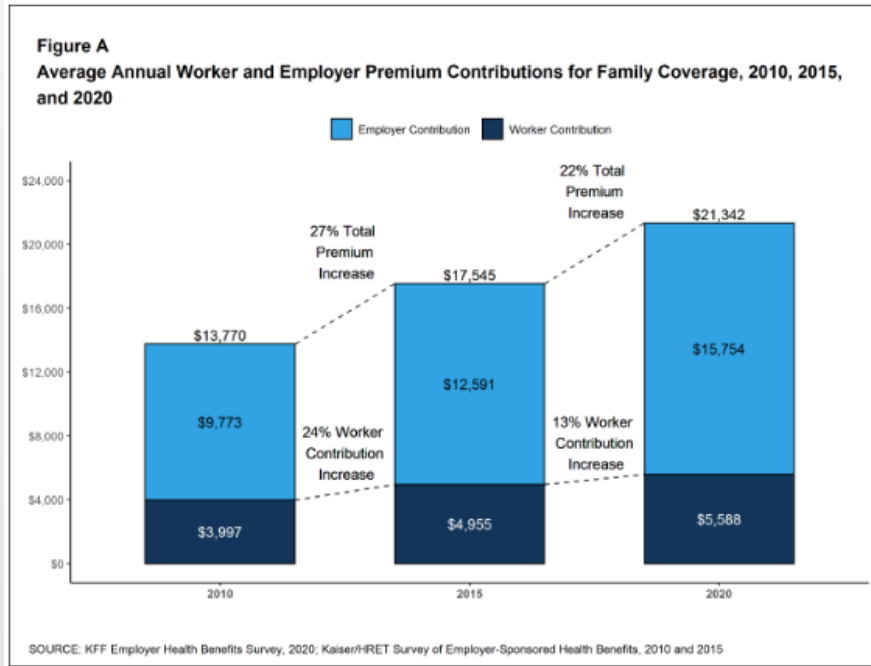
Illinois Health  
and Hospital  
Association

# National Health Expenditures



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

# Premiums and Out-of-Pocket Costs Continue to Increase



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*

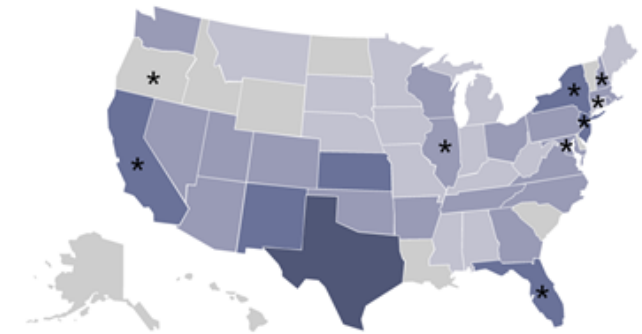
Health

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

**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

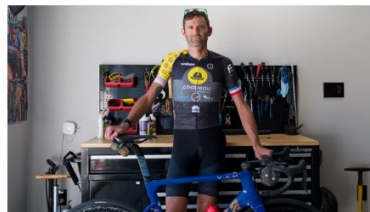
SHOTS - HEALTH NEWS

### 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

# No Surprises Act



Illinois Health  
and Hospital  
Association

# 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, 2020: CAA signed into law (includes NSA)
- July 13, 2021: Requirements Related to Surprise Billing; Part 1 (CMS-9909-IFC) published in *FR*
- Aug. 20, 2021: the Departments delay enforcement of certain NSA requirements for insured patients
- Sept. 10, 2021: Requirements Related to Air Ambulance Services, Agent and Broker Disclosures, and Provider Enforcement (CMS-9907-P) published in *FR*
- Oct. 7, 2021: Requirements Related to Surprise Billing; Part 2 (CMS-9908-IFC) published in *FR*
- **Effective Date: Jan. 1, 2022**

# NSA

- 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
- Outlines limited opportunity for providers to balance bill patients (some provisions not yet effective)
- Establishes negotiation and dispute resolution opportunities for providers and insurers
- 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
- HB4703 better aligns state with NSA (in Senate)

# NSA: Protections for Insured Patients

- 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

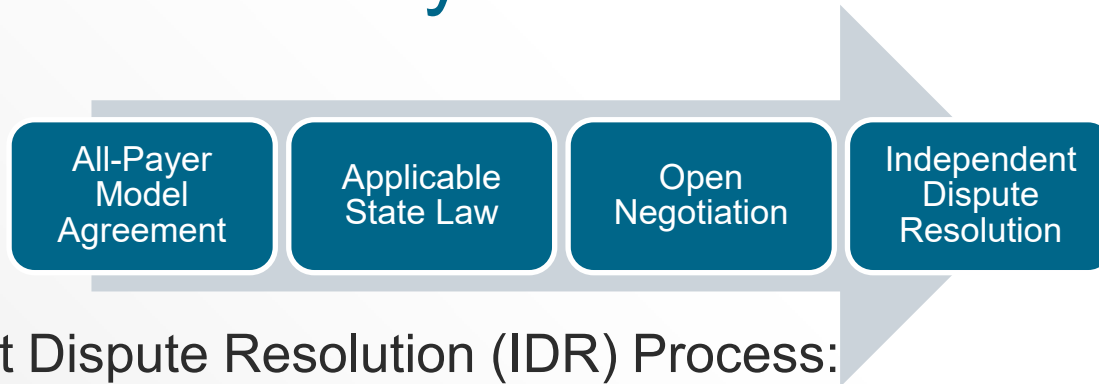


All-Payer Model Agreement

Applicable State Law

Qualifying Payment Amount (median in-network rate)

# Out-of-Network Payment



## Independent Dispute Resolution (IDR) Process:

- Regulations assume QPA is appropriate payment
  - Currently on hold due to pending lawsuits
  - Updated guidance forthcoming
- IDR entities must also consider additional credible information, including:
  - Training, experience, quality, and outcomes of provider
  - 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 out-of-network provider
  - Information about any good faith efforts (or lack thereof) made to enter into network agreements

# Notice and Consent (N&C)

- Limited opportunity to waive balance billing protections
  - Several associated requirements and limitations on use
- Expectation is N&C will be used sparingly
- The Departments created a form providers must use in N&C situations
  - Facility/provider must provide the patient’s insurer a good faith estimate (**enforcement delayed**)

## 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.

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

# Protections for Uninsured/Self-Pay Patients

- Facilities/providers must furnish a good faith estimate for uninsured/self-pay patients that schedule services or request a good faith estimate
  - Self-pay includes 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

# Uninsured/Self-Pay Good Faith Estimates

- All reasonably expected items/services and related charges from admission to discharge
- Convening provider responsible for delivering estimate to the patient
  - Must also include good faith estimate for co-providers (**delayed enforcement**)
- The Departments created a template that providers may use to create these good faith estimates
- Patients may dispute total billed charges through patient-provider dispute resolution process when \$400 or more than expected charges
  - Even when excess charges caused by unforeseen circumstances

# Public Disclosure of Patient Rights

## 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

## Continuity of Care

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

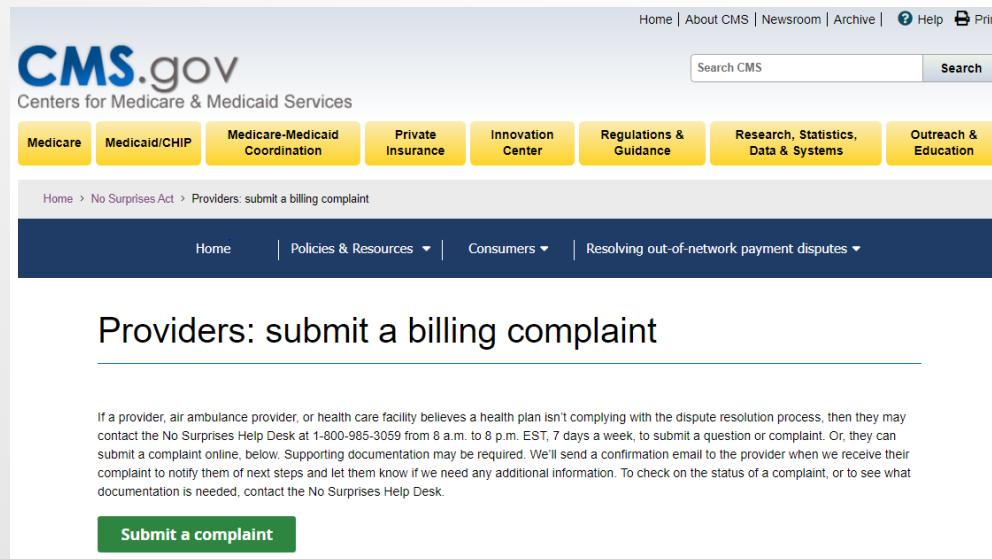
## Provider Directories

- 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

- States are primary enforcement authority (CMS backup)
  - Still no CAA enforcement letter for IL on CMS website
- Enforcement based on complaints/reports/audits
- Single complaint process
- Provider/Facility CMP: \$10,000/violation
  - CMS stated current enforcement focused on education/improvements



The screenshot shows the CMS.gov website interface. At the top, there is a navigation bar with links for Home, About CMS, Newsroom, Archive, Help, and Print. Below this is the CMS.gov logo and a search bar. A row of yellow buttons provides navigation for Medicare, Medicaid/CHIP, Medicare-Medicaid Coordination, Private Insurance, Innovation Center, Regulations & Guidance, Research, Statistics, Data & Systems, and Outreach & Education. The main content area is titled 'Providers: submit a billing complaint' and includes a paragraph explaining the process for submitting a complaint. A green button labeled 'Submit a complaint' is prominently displayed at the bottom of the page.

# Key Takeaways

- This is complex!
- Lots of rules and guidance are forthcoming = Uncertainty
- We are in a learning period
  - Delayed enforcement
  - CMS stressed importance of feedback, learning, and providers/payers' good faith efforts to be compliant
- Uncertainty around role/importance of QPA
  - Additional lawsuits are ongoing
- Assuming HB 4703 passes, applicability of Illinois' law depends on the health plan involved
- Illinois's role enforcing NSA requirements is unclear

# Resources

- CMS [fact sheets](#)
- CMS Provider Hotline: 1-800-985-3059
- CMS Billing Complaint [Portal](#)
- IHA [FAQs](#)
- IHA [Webinar](#) (password: dVvhPxxw6)
- IHA [summaries and fact sheets](#)



## NO SURPRISES ACT

DECEMBER 2021

### SURPRISE BILLING POLICIES EFFECTIVE JAN. 1, 2022

The following No Surprises Act (NSA) provisions go into effect on Jan. 1, 2022.

**Patient Balance Billing Protections:** Providers may not balance bill patients for certain out-of-network services including emergency care, post-stabilization services, and certain scheduled services, when the provider is out-of-network but the facility is in-network.

**Notice and Consent Process:** In some cases, providers may request patient consent to waive surprise billing protections and balance bill the patient. Providers must follow specific requirements outlined in the NSA and implementing regulations, including the use of standardized notice and consent forms available here: [CMS-10780](#).

**Federal Independent Dispute Resolution (IDR) Process:** The NSA established an IDR process for providers/facilities and plans/issuers that cannot reach an agreement on out-of-network reimbursement for items or services subject to NSA protections and delivered on or after Jan. 1, 2022. There is a federal IDR portal, available [here](#), where stakeholders can find more information, and initiate and complete the IDR process.

**Uninsured/Self-Pay Good Faith Estimates (GFE):** Providers must furnish GFEs of expected charges to uninsured/self-pay patients scheduling services three or more days out, or upon request. The GFE must include all items and services expected during the period of care, be calculated using self-pay rates, and reflect any discounts available to the patient (e.g., financial assistance). Each provider is responsible for generating their own GFE. The provider responsible for scheduling the primary service (convening provider) is responsible for coordinating estimates from providers billing separately from the convening provider (co-provider) into a single, comprehensive GFE by Jan. 1, 2023.

**Patient-Provider Dispute Resolution Process:** Uninsured/self-pay patients who receive a bill from a provider/facility for charges of \$400 or more than the provider/facility's GFE may initiate a dispute resolution process to assess the appropriateness of the increase.

**Public Disclosure of Patient Rights:** Providers/facilities must notify patients, both in writing and verbally, of their balance billing rights and the uninsured/self-pay GFEs. Providers/facilities also must post a disclosure of patients' rights on their websites and in their offices or facilities. The federal government provided a model disclosure form here: [CMS-10780](#). Illinois providers/facilities must modify this disclosure by including information related to patient protections under the State's surprise billing law, [PA 096-1523](#).

**Resources:** IHA resources to assist with NSA implementation are on IHA's [Price Transparency](#) and [Education](#) websites. These include a [webinar](#) describing hospital requirements under the NSA (password: dVvhPxxw6), a regularly updated FAQ [document](#), and summaries of NSA implementing regulations. The American Hospital Association also has a Surprise Billing [website](#) to assist AHA members with NSA implementation.

# Illinois Health and Hospital Association

[www.team-iha.org](http://www.team-iha.org)

Cassie Yarbrough

Senior Director

Medicare Policy

[cyarbrough@team-iha.org](mailto:cyarbrough@team-iha.org) or 630-276-5516



Illinois Health  
and Hospital  
Association