No Surprises Act Implementation: What to Expect in 2022

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Issue Brief

The No Surprises Act (https://www.kff.org/private-insurance/fact-sheet/surprise-medical-bills-new-protections-for-consumers-take-effect-in-2022/) (NSA) establishes new federal protections against surprise medical bills that take effect in 2022. Surprise medical bills (https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/) arise when insured consumers inadvertently receive care from out-of-network hospitals, doctors, or other providers they did not choose. Peterson-KFF (https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/) and other (https://zackcooper.com/sites/default/files/paper-files/w23623.pdf) studies find this happens in about 1 in 5 emergency room visits. In addition between 9% (https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0970) and 16% (https://www.healthsystemtracker.org/brief/an-examination-of-surprise-medical-bills-and-proposals-to-protect-consumers-from-them-3/) of in-network hospitalizations for non-emergency care include surprise bills from out-of-network providers (such as anesthesiologists) whom the patient did not choose. Surprise medical bills pose financial burdens on consumers when health plans deny out-of-network claims or apply higher out-of-network cost sharing; consumers also face "balance billing" from out-of-network providers that have not contracted to accept discounted payment rates from the health plan.[1] The federal government estimates the NSA will apply to about 10 million out-of-network surprise medical bills a year.

The NSA will protect consumers from surprise medical bills by:

- requiring private health plans to cover these out-of-network claims and apply in-network cost sharing. The law applies to both job-based and non-group plans, including grandfathered plans[2]
- prohibiting doctors, hospitals, and other covered providers from billing patients more than in-network cost sharing amount for surprise medical bills.

The NSA also establishes a process for determining the payment amount for surprise, out-of-network medical bills, starting with negotiations between plans and providers and, if negotiations don't succeed, an independent dispute resolution (IDR) process.

Federal agencies published two interim (https://www.govinfo.gov/content/pkg/FR-2021-07-13/pdf/2021-14379.pdf) final (https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf) regulations and another proposed (https://www.govinfo.gov/content/pkg/FR-2021-09-

16/pdf/2021-19797.pdf) rule this year to implement the law.[3] This brief summarizes key provisions that will take effect in 2022.

New federal protections apply to most surprise bills

Protections will apply to most surprise bills for specific types of services provided in certain settings.

Emergency Services – Surprise billing protections[4] apply to most emergency services, including those provided in hospital emergency rooms, freestanding emergency departments (https://www.healthaffairs.org/doi/10.1377/hlthaff.2016.0412), and urgent care centers that are licensed to provide emergency care. The federal law also applies to air ambulance transportation (emergency and non-emergency), but not ground ambulance (https://www.kff.org/private-insurance/issue-brief/ground-ambulance-rides-and-potential-for-surprise-billing/).[5] Emergency care includes (https://www.cms.gov/Regulations-and-Guidance/Legislation/EMTALA) screening and stabilizing treatment sought by patients who believe they are experiencing a medical emergency or active labor.

The federal government estimates there are 39.7 million emergency visits annually by patients with private job-based or individually purchased insurance, and of these 18% (or about 7.1 million visits) will involve at least one out-of-network claim.

Post-emergency stabilization services – The NSA defines emergency services to also include post-stabilization services provided in a hospital following an emergency visit. Post-stabilization care is considered emergency care until a physician determines the patient can travel safely to another in-network facility using non-medical transport, that such a facility is available and will accept the transfer, and that the transfer will not cause the patient other unreasonable burdens. The NSA also requires patients must receive written notice and give written consent to be transferred.[6] The federal government estimates each year 4.1 million emergency department visits result in a hospital admission, and that 16% (or about 660,000) of these admissions will involve at least one out-of-network claim.

Non-emergency services provided at in-network facilities – Finally, the NSA covers non-emergency services provided by out-of-network providers at in-network hospitals and other facilities. Often, the doctors who work *in* hospitals don't work *for* the hospital; instead they bill independently and do not necessarily participate in the same health plan networks. The federal government estimates that 16% of 11.1 million (or about 1.8 million) in-network non-emergency facility stays for privately insured patients each year involve at least one out-of-network claim.

The regulation broadly defines covered non-emergency services to include treatment, equipment and devices, telemedicine services, imaging and lab services, and preoperative and postoperative services, regardless of whether those services are provided within the facility itself.

The interim final regulation defines “facility” to include hospitals, hospital outpatient departments, and ambulatory surgery centers. It requests public comment on whether additional types of facilities should be added to this definition. Meanwhile, consumers do not have federal protections against surprise bills for non-emergency services provided in other facilities such as birthing centers, clinics, hospice, addiction treatment facilities, nursing homes, or urgent care centers. Patients seeking care at such facilities may want to ask whether doctors bill independently and whether they are in network.

Doctors and hospitals must not bill patients more than the in-network cost sharing amount for surprise bills

For services covered by the NSA, providers are prohibited from billing patients more than the applicable in-network cost sharing amount; a penalty of up to $10,000 for each violation can apply.

Today, many out-of-network doctors and hospitals bill patients directly for their full, undiscounted fee, leaving to patients to submit the out-of-network claim to their insurance and collect what reimbursement they can. That common billing practice will change starting next year. Providers will need to first find out the patient’s insurance status and then submit the surprise out-of-network bill directly to the health plan. Providers are “encouraged” to include information about whether NSA protections apply on the claim itself (including, whether the patient has consented to waiver her balance billing protections, described below.) Health plans must respond within 30 days, advising the provider of the applicable in-network cost sharing amount for that claim; cost-sharing generally will be based on the median in-network rate the plan pays for the service.[7] The health plan will send an initial payment to the provider and send the consumer a notice (called an explanation of benefits, or EOB) that it has processed the claim and indicating the in-network cost sharing amount the patient owes the out-of-network provider. Only at this point is the out-of-network provider allowed to send the patient a bill for no more than the in-network cost sharing amount.

How will consumers know if a bill or claim constitutes a surprise medical bill? – It is up to both providers and health plans to identify bills that are protected under the NSA. The regulations also request public comment on whether changes to federal rules governing electronic claims (so-called HIPAA standard claims transactions) are needed to indicate claims for which surprise billing protections apply.[8]

Providers and plans also must notify consumers of their surprise medical bill protections. Providers and facilities must post a one-page disclosure notice (https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780) summarizing NSA surprise billing protections on a public website and give this disclosure to each patient for whom they provide NSA-covered services. (Appendix 1 (https://www.kff.org/report-section/no-surprises-act-implementation-what-to-expect-in-2022-appendices)) This notice must be provided no later than the date when payment is requested, though the regulation specifies it is not required to be included with the bill, itself. Health plans are also required to provide consumers the disclosure notice with every EOB that includes a claim for surprise medical bills.

If a health plan or provider (or both) fail to properly identify a surprise bill, it will be up to the patient to recognize that NSA protections should apply and seek relief.

Some providers can ask consumers to waive rights

An exception to federal surprise billing protections is allowed if patients give prior written consent (https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780) to waive their rights under the NSA and be billed more by out-of-network providers. Providers are never allowed to ask patients to waive their rights for emergency services or for certain other non-emergency services or situations described above. Consent must be given voluntarily and cannot be coerced, although providers can refuse care if consent is denied.

Notice and Consent Waiver Not Permitted for:

- Emergency services
- Unforeseen urgent medical needs arising when non-emergent care is furnished
- Ancillary services, including items and services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology
- Items and services provided by assistant surgeons, hospitalists, and intensivists
- Diagnostic services including radiology and lab services
- Items and services provided by an out-of-network provider if there is not another in-network provider who can provide that service in that facility

Federal regulations provide for a standard waiver consent form (https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780), improbably titled the "Surprise Billing Protection Form," (Appendix 2 (https://www.kff.org/report-section/no-surprises-act-implementation-what-to-expect-in-2022-appendices)) that must include key information, including

- a statement that the patient is not required to waive protections, and can try to find an in-network provider/facility instead (for post stabilization care, the notice must indicate the name of available in-network providers)
- a statement that the out-of-network provider/facility can refuse to treat if the patient refuses to waive surprise billing protections
- a statement that waiving protections could cost the patient more money in out-of-network charges
- a description of the out-of-network services to be provided, along with billing codes and a good faith (nonbinding) estimate of costs the patient may owe

The law requires that consent must be given at least 72-hours in advance or, if the patient schedules a service less than 72-hours in advance, no later than the day the appointment is made. For same-day scheduled services, regulations permit consent to be given at least 3 hours in advance. It is possible, for example, that an out-of-network doctor could ask an already-hospitalized patient in the morning to waive her NSA protections for a service the doctor schedules to be given later that afternoon.

Providers should not seek consent to waive protections from patients who are impaired or otherwise limited in their ability to make informed decisions. The waiver form must also be provided in the 15 most common languages in the geographic region where consent is sought; and if the patient's own language is not among those, qualified interpreter services must be provided. The patient's signature is required to give consent; no provider signature is required. Consent can be revoked prior to services being provided. The out-of-network provider or facility is required to notify the health plan that patient consent to waive balance billing protections for the claim(s) was appropriately given.

The Departments express the view that consent to waive NSA protections should be obtained only in limited circumstances – where the patient knowingly and purposefully seeks care from an out-of-network provider – and not to circumvent the law's consumer protections. Even so, the regulation estimates that consumers will give consent to waive NSA protections in 50% of post-stabilization claims and for 95% of non-emergency services provided at in-network facilities. The regulations do not require any data reporting to regulators on the number of consent waivers given or for what services or providers. Agencies asked for comment on whether further limits on the notice-and-consent waivers are advisable.

Some state laws (https://surprisemedicalbills.chir.georgetown.edu/state-efforts/) either do not allow waiver of protections or requiring greater advanced notice.

How will enforcement work?

For consumers to be protected, both the health plan and the surprise billing provider will need to comply with the law. If problems arise, consumers might need to seek help from more than one enforcing agency. And, though the NSA is a federal law, states will also have a role in enforcement.

Enforcement against health plans and insurers – The federal government has exclusive enforcement responsibility for most private health plans, though different federal agencies may be involved. States will lead enforcement for state-regulated plans.

- Most Americans under age 65 are covered by private employer-sponsored health plans, with nearly 2/3 of covered workers (https://www.kff.org/report-section/ehbs-2021-summary-of-findings/) in self-insured plans that states are preempted from regulating. Enforcement authority over private self-insured employer-sponsored group plans rests with the U.S. Department of Labor (DOL) and Department of Treasury. Fully-insured group plans will be primarily regulated by states
- For fully insured group health plans and individual health insurance, states have primary enforcement authority, with federal fallback enforcement by HHS triggered when states do not substantially enforce. Any information (e.g., complaints, news stories) can serve as the basis for HHS investigating state enforcement.
- For self-insured plans sponsored by non-federal public employers, the U.S. Department of Health and Human Services (HHS) has primary enforcement authority. Agencies estimate 3 million (https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf) people are enrolled in these plans.
- For the Federal Employees Health Benefits Program (FEHBP), enforcement authority rests with the U.S. Office of Personnel Management (OPM). The FEHBP is the largest employer-sponsored group health plan, coving nearly 9 million (https://www.opm.gov/retirement-services/publications-forms/pamphlets/ri75-13.pdf) federal employees, annuitants and family members.

The NSA requires DOL to conduct audits of claims data from up to 25 group health plans annually to monitor employer-sponsored plan compliance with the NSA and to report to Congress annually on audit findings. HHS also will conduct up to 9 audits annually of compliance by state and local government employer plans and other issuers in states that are not substantially enforcing the NSA. These annual audits will focus primarily on whether plans are following the methodology for calculating QPAs.[9]

Enforcement against providers – States have a primary role in enforcing NSA rules against health providers, with federal enforcement as back up. This is true even when the consumer is covered by a federally-regulated health plan. It is yet to be determined which agency(ies) in each state will enforce NSA provider requirements, for example, the attorney general, department of health, hospital commission, or medical licensing boards. In addition, to “proactively identify and address issues of noncompliance,” HHS has proposed that it will conduct on average 200 random or targeted investigations per month into potential violations of NSA requirements by providers, starting in 2022.

Federal vs. state enforcement – This fall, the federal government surveyed (https://www.cms.gov/files/document/caa-state-enforcement-survey.pdf) states to learn about their authority and intention to enforce each of the major provisions under the NSA. The survey asked states if they will elect or decline to assume enforcement authority on a provision-by-provision basis. States can also enter into a collaborative enforcement agreement with the federal government, under which the state would seek voluntary compliance from health plans or providers and, when it cannot obtain that, refer cases to the federal government for enforcement action. Many states (https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections?redirect_source=/publications/maps-and-interactives/2019/jul/state-balance-billing-protections) have already enacted some surprise billing protections for consumers in state-regulated plans. Depending on limits of their laws and authority, it is possible some states might decline to enforce NSA protections for certain services (e.g., post-stabilization) or for certain types of health plans (e.g., PPOs vs. HMOs), or with respect to certain providers (e.g., air ambulance). In addition, state laws may be more protective than the NSA in certain respects (for example, a state law might apply to ground ambulance services) in which case a state would enforce its own stronger protections, at least with respect to state-regulated health plans.

It is expected that HHS will make survey results public or otherwise publish a directory of applicable state and federal enforcement agencies. Health plans and providers must give consumers a disclosure notice summarizing protections under the NSA and state laws, and this must include the name and contact information for applicable enforcement agencies. (Appendix 1 (https://www.kff.org/report-section/no-surprises-act-implementation-what-to-expect-in-2022-appendices))

If problems do arise, it is conceivable that a patient might need the help of multiple agencies – federal, state, or both. For example:

- If a US DOL-regulated group health plan incorrectly denies a claim for an out-of-network service to which the NSA applies, and as a result, if the provider then incorrectly bills the patient for the entire charge, the consumer might need to rely on US DOL to enforce against the group health plan and on a state agency to enforce against the provider.
- If a patient requires post-stabilization care following an emergency visit and her state surprise billing law covers emergency services only, she might need to rely on the state to enforce protections for the emergency claims and on the federal government for claims involving the post-stabilization care.
- If a patient receives an out-of-network emergency surprise bill while traveling (https://www.npr.org/sections/health-shots/2021/07/29/1021197432/cyclists-olympic-dream-becomes-200-000-medical-bill-nightmare) in another state, he might need to request help from the federal government if his home state, which would otherwise enforce NSA rules on providers, declines to enforce against out-of-state providers.

What can consumers do in case of problems?

Health plans, providers and facilities will most likely work in good faith to comply with NSA requirements. Even if compliance rates are high, with 10 million surprise medical bills annually, hundreds of thousands of problems could nonetheless arise. In such cases, it could fall to the consumer to recognize when surprise billing protections should apply and to seek help.

Consumers can appeal health plan denials – NSA gives consumers the right to appeal health plan decisions to incorrectly deny or apply out-of-network cost sharing to surprise medical bills, first to the health plan, and then, if the plan upholds its decision, to an independent external reviewer. NSA interim final regulations (https://www.govinfo.gov/content/pkg/FR-2021-10-07/pdf/2021-21441.pdf) added surprise bills to the scope of claims eligible for external appeal, which is otherwise limited to only denials based on medical necessity. NSA regulations made no other changes to current federal standards (https://www.kff.org/private-insurance/issue-brief/consumer-appeal-rights-in-private-health-coverage) and processes that can limit consumer access to external appeal, including those that:

- require the health plan to determine which claims are eligible for external appeal
- require employer-sponsored health plans to contract with the external reviewer
- limit access to denial notices in another language for consumers with limited English proficiency

Federal appeals standards apply to most private health plans sponsored by employers, although in some states appeal rights are stronger for consumers in state-regulated health insurance.

Beyond these limitations, appeal rights may not help in many cases because consumers rarely appeal adverse determinations by their health plans. Data (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/) reported by qualified health plans sold on HealthCare.gov show less than 2/10 of 1% of denied claims are appealed internally to the health plan, and less than 3% of those appeals make it to external review. There is no reporting requirement specific to surprise medical bill claims and appeals for QHPs, and at present, federal law requirements on employer-sponsored health plans to report data on denied claims have never been implemented.

Consumers can contact "the applicable enforcement entity" when providers incorrectly bill – Providers are required to give consumers written notice describing their federal protections each time they provide a service protected under the NSA. The notice must include contact information for the applicable federal and state enforcement entities; although a provider that inappropriately balance bills for a service subject to the NSA might also fail to provide the required disclosure notice.

A national consumer complaints system will be established – The NSA requires HHS to establish a national complaints system for surprise medical bills, which is currently under development (https://www.cms.gov/nosurprises) and scheduled to go live on January 1, 2022.

The toll free number for the "No Surprises Help Desk" will be 1-800-985-3059.

A central, no-wrong-door system is contemplated where consumers can register complaints regarding suspected violations by providers and facilities. The HHS system will also accept complaints related to suspected violations by health plans. It will coordinate with complaints systems operated by US DOL for group health plans and by OPM for the federal employee health plan and with state insurance regulators. Federal agencies are contemplating requirements to include contact information for the national Help Desk on other key documents, such as health plan EOBs, provider bills, or consent waiver forms.

The interim final regulations say HHS will respond to filed complaints within 12 weeks (60 business days), though agency staff have indicated that consumers will receive real-time confirmation when a complaint is filed. Agency staff also indicate plans to conduct preliminary review of complaints within 3 to 5 days of receipt to determine any additional information that may be needed to process the complaint. Once processed, HHS will refer the consumer to another Federal or State regulatory agency to investigate or, if applicable, inform the complainant of action HHS has taken to resolve the problem or refer the matter for enforcement. It is still to be determined whether HHS will track the outcome of complaints it refers to other agencies, or whether or how HHS will use the complaint system to track compliance by plans and providers or enforcement activities of states. HHS estimates the system will receive 3,600 provider-related complaints annually; it will cost an estimated $16 million to build the online complaints system and ongoing operating costs of $10 million annually.

Consumers can contact their state Consumer Assistance Program (CAP) – The Affordable Care Act (ACA) provided for the establishment of state ombudsman programs or CAPs to educate privately insured consumers about their health coverage and rights and to help consumers resolve problems with health plans, including filing appeals. Forty CAPs were established in 2010, though no federal CAP funding has since been appropriated. Most (https://www.dol.gov/sites/dolgov/files/EBSA/laws-and-regulations/laws/affordable-care-act/for-employers-and-advisers/consumer-assistance-programs.doc) remain in operation today, at least at reduced levels, and help patients with medical bill problems (https://www.cssny.org/publications/entry/community-health-advocates-annual-report-2020), including surprise medical bills (https://www.marylandattorneygeneral.gov/press/2021/110421.pdf). Other legislation pending in Congress – the Build Back Better Act (https://rules.house.gov/sites/democrats.rules.house.gov/files/Section_by_Section_BBB_RCP117-18__.pdf) and the FY 2022 Labor-HHS appropriations (https://www.appropriations.senate.gov/imo/media/doc/LHHSREPT_FINAL3.PDF) bill – together could provide $75 million in new funding for CAPs in 2022, enabling states to establish new or expand existing programs. In addition to helping individual consumers resolve problems, CAPs are required to report to HHS on the kinds of problems consumers encounter. This data can inform oversight, as well as policy changes that can prevent problems from happening again. CMS staff indicate that the national surprise medical bill complaints system will also be able to refer complainants to the CAP in their state for local assistance.[10]

How will payments for surprise bills be determined?

The amount paid for surprise out-of-network surprise bills will likely end up close to the median rate that plans pay in-network providers in a geographic area, also known as the qualifying payment amount, or QPA.[11] Under the law, the patient's cost sharing for a surprise medical bill must be based on the QPA. Health plans and providers can negotiate privately over the amount to be paid for the surprise bill, and if they can't agree, either party can ask for an Independent Dispute Resolution (IDR) process to decide the payment amount. However, there are strong incentives for both plans and providers to either rely on the QPA or on private negotiations.

The federal IDR process will be conducted by certified entities chosen by HHS and will resemble so-called baseball-style arbitration.[12,13] The plan and provider will each submit their best offer for the out-of-network payment amount for a claim. The IDR entity begins with the presumption that the QPA is the correct amount but can consider other factors, including patient acuity, the level of training and expertise of the treating provider, the market shares of both parties, and past good faith efforts of both parties to reach a network agreement. The IDR entity then chooses the offer it determines to be most appropriate, which becomes the out-of-network payment for that bill. The IDR will charge a fee for each arbitration and the losing party must pay that fee. (IDR fees can range from $200 to $500 for a single case, and $268 to $670 for multiple or "batch" determinations.)[14]

In light of this process and incentives, HHS estimates the IDR process will be invoked for just over 17,300 surprise medical bill claims per year, and for another roughly 4,900 surprise air ambulance bills per year. The Congressional Budget Office also estimates this process will tend to have a dampening effect on the cost of surprise bills; CBO (https://www.cbo.gov/system/files/2021-01/PL_116-260_div%20O-FF.pdf) estimates the NSA will reduce private health plan premiums by 0.5% to 1% on average, and reduce the federal deficit by $17 billion over 10 years. Studies (https://www.brookings.edu/opinions/surprise-medical-bills-increase-costs-for-everyone-not-just-for-the-people-who-get-them/) have found that surprise medical bills otherwise increase overall health insurance costs because the ability to balance bill gives certain providers and facilities leverage to negotiate much higher prices with insurers. To the extent that NSA moderates that dynamic, it can reduce health plan costs overall in addition to reducing out-of-pocket costs for individual patients.

Organizations representing providers (https://www.texmed.org/uploadedFiles/Current/2016_Advocacy/Surprise_Billing_Lawsuit_102821.pdf) and air ambulance (https://www.airmedandrescue.com/latest/news/association-air-medical-services-sues-us-government-over-no-surprises-act-rules) companies have objected, however, and filed lawsuits urging that regulations should not have created a 'rebuttable presumption' in favor of the QPA. It remains to be seen if these actions may result in delayed implementation of the NSA or in changes to regulatory standards and procedures that could result in greater use of the IDR process or the determination of higher out-of-network payments.

The regulations also require detailed monthly reporting to HHS by IDR entities on the cases they receive. Data required to be sent to HHS includes specific information on the parties involved in each arbitration – including their names, market share, and other characteristic – and on the services involved – including the dollar amounts offered by each party, also expressed as a percentage of the QPA. HHS will compile data into quarterly reports that will be publicly available. These reports could provide an additional degree of transparency around surprise medical bills and the characteristics of plans and providers involved in surprise billing disputes.

Discussion

The No Surprises Act creates important new federal protections against surprise medical bills – a leading cause of affordability (https://www.kff.org/health-costs/poll-finding/data-note-public-worries-about-and-experience-with-surprise-medical-bills/) concerns for consumers. That this law passed with strong bipartisan support is an indication of the need for these protections. That federal agencies moved swiftly to implement the new law signals intent to make it work as effectively as possible.

The law is highly complex, however, setting coverage and billing standards for a specific subset of private insurance claims that could number 10 million annually. Providers are permitted to ask consumers to waive their NSA protections in some cases. Oversight and enforcement will be conducted by an array of federal and state agencies, some of which are still to be determined, and more than one of which could be involved in any given case of noncompliance.

Monitoring of the law's impact, as well as compliance, will be accomplished in various ways. Data reporting by IDR entities will provide some information about prices for surprise bills and the characteristics of plans and providers using the IDR process. Annual health plan audits conducted by federal agencies can also yield information about prices charged and paid for surprise bills. Other targeted audits and investigations can yield information about compliance generally, as can new federal consumer complaints systems. State systems may also yield important data as to how the law is working, such as state complaints systems and analysis of data from all-payer-claims databases. It remains to be seen how these new systems will work, independently and in coordination.

To a large extent, oversight and enforcement will rely on complaints. In order to complain, though, consumers will need to understand that they should not be overbilled for emergency services or for non-emergency out-of-network services while they are in in-network hospitals and facilities. How public education will be conducted, and how public understanding of new rights will be monitored is yet to be determined. The responsiveness of new complaints systems and how they coordinate will also be important to watch.

Finally, it remains to be seen if any other tools will be employed to monitor trends in the incidence of surprise medical bills, and how effectively the law may work to protect consumers from surprise bills and reduce their out-of-pocket costs. For example, might the federal government exercise its broad authority under the ACA to require transparency data (https://www.kff.org/private-insurance/issue-brief/claims-denials-and-appeals-in-aca-marketplace-plans/) reporting by private health plans? This authority could be used to monitor the incidence of surprise medical bills over time, as well as differences between the QPA and billed or paid out-of-network charges; it could also be used to monitor how frequently providers use consent waivers. Or, will state consumer assistance programs be employed to play a role in educating the public, reporting to regulators on problems that arise and how they might be prevented in the future?

As implementation proceeds (and as federal courts consider legal challenges to the regulations) it is also possible that NSA standards and procedures will be modified further.

Appendices

Appendix 1: Disclosure Notice Summarizing NSA Protections

> Federal regulations include this one-page model notice (https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780) (two-sided) that health plans and providers are required to give to patients notifying them of their rights under the federal No Surprises Act. This model notice could change in the future pursuant to public comments.

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 balanced 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].]

Appendix 2: Standard Consent Form to Waive Protections

> Federal regulations include this standard consent form (https://www.cms.gov/httpswwwcmsgovregulations-and-guidancelegislationpaperworkreductionactof1995pra-listing/cms-10780) that providers and facilities must use to ask patients to waive their balance billing protections under the No Surprises Act. This standard form could change in the future pursuant to public comments.

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:	

►**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 (1) specific information about prior authorization or other care management limitations that are or may be required by the individual's health plan or coverage, and the implications of those limitations for the individual's ability to receive coverage for those items or services, or (2) include the following general statement:*

Except in an emergency, your health plan may require prior authorization (or other limitations) for certain items and services. This means you may need your plan's approval that it will cover an item or service before you get them. If prior authorization is required, ask your health plan about what information is necessary to get coverage.]

[*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.

By signing, I give up my federal consumer protections and agree to pay more for out-of-network care.

With my signature, I am saying that I agree to get the items or services from (select all that apply):

☐ [*doctor's or provider's name*] [*If consent is for multiple doctors or providers, provide a separate check box for each doctor or provider*]

☐ [*facility name*]

With my signature, I acknowledge that I am consenting of my own free will and am not being coerced or pressured. I also understand that:

- I'm giving up some consumer billing protections under federal law.
- I may get a bill for the full charges for these items and services, or have to pay out-of-network cost-sharing under my health plan.
- I was given a written notice on [*enter date of notice*] explaining that my provider or facility isn't in my health plan's network, the estimated cost of services, and what I may owe if I agree to be treated by this provider or facility.
- I got the notice either on paper or electronically, consistent with my choice.
- I fully and completely understand that some or all amounts I pay might not count toward my health plan's deductible or out-of-pocket limit.
- I can end this agreement by notifying the provider or facility in writing before getting services.

IMPORTANT: You **don't** have to sign this form. But if you don't sign, this provider or facility might not treat you. You can choose to get care from a provider or facility in your health plan's network.

____ or
____

Patient's signature Guardian/authorized
representative's signature

____
____

Print name of patient Print name of guardian/authorized
representative

___________________________ ___________________________

Date and time of signature Date and time of signature

Take a picture and/or keep a copy of this form.

It contains important information about your rights and protections.

More details about your estimate

Patient name:____

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

____

The amount below is only an estimate; it isn't an offer or contract for services. This estimate shows the full estimated costs of the items or services listed. It doesn't include any information about what your health plan may cover. **This means that the final cost of services may be different than this estimate.**

Contact your health plan to find out how much, if any, your plan will pay and how much you may have to pay.

[*Enter the good faith estimated cost for the items and services that would be furnished by the listed provider or facility plus the cost of any items or services reasonably expected to be provided in conjunction with such items or services. Assume no coverage would be provided for any of the items and services.]*

[*Populate the table below with each item and service, date of service, and estimated cost. Add additional rows if necessary. The total amount on page 2 must be equal to the total of each of the cost estimates included in the table*.]

Date of service	Service code	Description	Estimated amount to be billed
		Total estimate of what you may owe:	

Endnotes

Issue Brief

1. Balance bill refers to the difference between the full undiscounted charge and the amount the health plan recognizes as reasonable. Studies (https://aspe.hhs.gov/sites/default/files/documents/acfa063998d25b3b4eb82ae159163575/no-surprises-act-brief.pdf) have found the average balance billing charge for surprise bills was over $1,200 for anesthesia, $2,600 for surgical assistants, and $750 for childbirth.

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2. The No Surprises Act does not apply to Medicare or Medicaid, public programs that already strictly limit or prohibit balance billing by nonparticipating providers.

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3. “Interim final” means the regulations take effect, but public comment is requested and future amendments are possible.

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4. In addition to surprise billing protections, the No Surprises Act sets other standards for private health plan coverage of emergency care. For example, health plans will be prohibited from denying claims for emergency care simply because the patient turned out to not be experiencing a medical emergency (for example, if a patient sought emergency care for chest pain that turned out to be caused by indigestion instead of a heart attack).

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5. The law establishes an advisory committee to make recommendations on whether and how Congress might apply federal surprise medical bill protections for ground ambulance services. Meanwhile ten (https://www.commonwealthfund.org/blog/2021/protecting-consumers-surprise-ambulance-bills) states do provide surprise medical bill protections for ground ambulance services.

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6. The consent form is shown at Appendix 2. The form is not required to include information stating that the patient is medically able to be transferred nor does it require a signature by the medical professional certifying the patient's condition.

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7. In states with an all-payer rate setting system or other state law determining payment rates for surprise medical bills, patient cost sharing could be based on the state-determined amount.

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8. For example, as part of implementation of its surprise bill law, the state of Washington requires insurers to include a standardized transaction code (https://apps.leg.wa.gov/wac/default.aspx?cite=284-43B-040) on all claims subject to that state's balance billing law in order to notify providers that state law applies to the claim; Washington also requires a standard code must be included on EOBs to notify consumers (https://apps.leg.wa.gov/wac/default.aspx?cite=284-43B-050) that a claim is subject to state law balance billing protections.

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9. In addition to the statutorily required numbers of health plan audits, DOL and HHS can undertake any number of additional investigations or audits in response to complaints.

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10. CMS staff comments offered during meeting with consumer advocates on NSA implementation, November 30, 2021.

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11. In states with an all-payer rate setting system or other state law determining payment rates for surprise medical bills, the QPA could be the state-determined amount.

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12. HHS is currently taking applications from entities to be certified IDRs (https://www.cms.gov/nosurprises/help-resolve-payment-disputes/submit-feedback-on-applicants) and expects to certify 50 entities. States with their own surprise medical bill laws can apply a different state-designed IDR process to resolve payment disputes involving state-regulated plans. Currently, several states also allow plans they don't regulate (self-insured employer plans) to elect to use the state IDR process if they prefer.

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13. The No Surprises Act also establishes a payment dispute resolution process for providers and uninsured (or self-pay) patients. Under the law, uninsured patients have the right to request a good faith estimate of the cost of care they seek; if the actual amount charge is significantly in excess of the estimated amount (by at least $400), the patient can ask an IDR entity selected by HHS – the selected dispute resolution, or SDR entity – to review the charges and determine whether they should be reduced. In the regulations HHS estimates about 3.5 million uninsured or self-pay individuals will receive good faith cost estimates annually, and the SDR will be asked to review 26,659 cases annually.

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14. In addition each party pays a $50 administrative fee to use the IDR process.

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