RULES & REGULATIONS

NO SURPRISES ACT

Deadlines and Agencies responsible for rulemaking on key aspects of the *No Surprises Act*

JULY 1, 2021

"RECOGNIZED AMOUNT" DEFINITION
CMS: CCIIO

The Secretary should enforce transparency of insurance plans and the "recognized amount" and determine enforcement measures and penalties. Insurers must be required to clearly indicate patients' cost-sharing amounts, if any, to enrollees and providers. This information may be communicated on member ID cards, EOBs and ERAs. This is necessary for clarity of determining a patient's cost-sharing amount, whether state or federal law applies, avoid confusion about the IDR timelines and limit administrative burden.

ALL PAYER CLAIMS DATABASE
HHS AND DOL

The APCD should permit and not replace databases, such as FairHealth (or similar data sets), for use in determining the initial and final payment standards in states with existing Surprise Billing Laws (e.g., NY, TX, GA). Regulators should not introduce additional stipulations on prohibitions of data factors to be considered in IDR and should avoid extrapolating the exclusion of "usual and customary amounts" to these datasets.

ERISA PLANS
HHS AND DOL

Regulators should mandate a clear and uniform IDR process for procedures governing all ERISA plans within a state. This will ensure that physicians have minimal protections, increase compliance and reduce IDR related administrative costs, regardless whether a state permits ERISA plans to opt into state law.

"QUALIFYING PAYMENT AMOUNT" (QPA) DEFINITION
CMS: CCIIO

The Median Contracted Rate (MCR) must be fairly calculated and free from insurer manipulation. MCRs should be calculated upon a weighted average of individually paid claims in the applicable geo-zip location for the specialty providing the service. The MCR must be anchored to January 31, 2019 and adjusted by the CPI. Insurers should not be permitted to self-select an MCR, confound service rates amongst multiple specialities or cherry-pick what rates are used to calculate the MCRs.

FEDERAL & STATE LAW INTERACTIONS
HHS AND DOL

Regulators must avoid language that prohibits access to meaningful IDR for emergency medical care. The Federal law must be held as a minimal standard and accessible for payment disputes, regardless of ERISA plan status, for providers in states with inadequate or inaccessible IDR processes.

"INITIAL PAYMENT" & "DENIAL OF PAYMENT" DEFINITIONS
CMS: CCIIO

The Secretary should maintain the ability for parties to pursue other resolutions to payment disputes, including the option to opt out of an IDR process (if both parties agree) and to file suit. Parties should not have to wait until the IDR period has ended to resolve disputes if another resolution process exists.

JULY - SEPTEMBER 2021

EXPECTED RELEASE OF INTERIM RULES & REGS
CMS: CCIIO

Likely release of interim rules and regulations with a subsequent public comment period. It is possible that issues with deadlines past this date (e.g., IDR Process) may be included in the interim rules released at this time.

DECEMBER 27, 2021
ONE YEAR AFTER ENACTMENT

CLAIMS BATCHING
CMS: CCIIO

Batching of claims must be widely accessible and not fraught with administrative burden. The provider must have the option to batch similar claims for a given payer, at either the individual practitioner or TIN level. The Secretary should ensure that the arbiters are not required to resolve all codes in favor or one side or the other in batched claims.

IDR CRITERIA & PROCESS
CMS: CCIIO

The IDR process must treat all data presented equally in consideration unless specifically excluded by the law. "Good faith efforts" should be clearly defined and enforced (e.g., by default payment amount or fee) to prevent entities from ignoring the IDR process. Arbiters must be non-biased. The IDR process must not be administratively burdensome or have excessive fees that limit access and discourage participation.

JANUARY 1, 2022 — NSA GOES INTO EFFECT