NO SURPRISES ACT: A COMPLIANCE REFRESHER

JAKE S WALKER

(9/26)

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Agenda

1. Background
2. Balance Billing Requirements
3. Federal IDR Process & Changes
4. Enforcement Landscape
5. Self-Pay / Uninsured Protections
6. Compliance

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History

- Govt concerned about:
  - Insured patient receives and is on the hook for unexpected medical bill from out-of-network ("OON") facility or provider
  - Uninsured or self-pay patient receives unexpected medical bill
- Response:
  - No Surprises Act
    - Title I of Division BB of the Consolidated Appropriations Act ("CAA") for 2021
  - No Surprise Billing Rules
    - 45 CFR part 149
    - Effective January 1, 2022

NSA at 5 Years

- Effective Date: January 1, 2022
- Main winners: patients
- Backlog of IDR
  - Originally gov't predicated about 17,000 IDR cases a year
  - 2025: 2.5 million*
- Providers win a majority of disputes
  - 2023 – 2025 average: 82.2% win rate*
  - Payment of awards is a different story
- State enforcement varies
- Continuously influx between litigation and regulatory changes

*Niskansen Center

NSA Framework

The No Surprises Act

Subpart B: Issuer and Plan Requirements

Subpart E: Provider and Facility Prohibitions

Subpart G: Uninsured & Self-Pay Protections

Subpart F: Federal IDR

Subpart G: PPDR

2. Balance Billing Requirements

Subpart B: Plan / Issuer *Requirements*

- Emergency Services
  - No prior authorization required
  - Cover at in-network cost-sharing levels
  - Applies regardless of whether provider/facility is in-network
  - No limitation based on diagnosis codes
- Non-Emergency Participating Facilities
  - Limit cost sharing to in-network levels
  - Applies when OON provider treats patient at in-network facility
  - Must determine whether covered within 30 calendar days after bill is transmitted by provider

(45 CFR 149.110 – 120)

Subpart E: Provider / Facility
Prohibitions

Emergency Services

- Emergency services are provided by an OON provider or OON emergency facility
- *Facility = emergency dept of hospital or independent freestanding emergency dept as licensed by state (may include urgent care center)*

- OON provider or facility cannot bill individual for payment amount greater than in-network cost sharing

(45 CFR 149.410 – 420)

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Subpart E: Provider / Facility
Prohibitions

Emergency Services Exception

- May balance bill for post-stabilization services if attending emergency phys. or treating provider determines:
  - Can travel to an in-network provider or facility within a reasonable distance using non-medical or non-emergency transportation
  - In a condition to receive notice and provide informed consent
  - OON provides individual with written notice and consent
  - Satisfies state law requirements

(45 CFR 149.410 – 420)

Subpart E: Provider / Facility
Prohibitions

Non-Emergency Services

- Non-emergency services are provided by an OON provider at an in-network health care facility
- *Facility = hospital, hospital outpatient dept, CAH, or ASC that has a contract with a health plan covering the services provided, including single case agreements*

- OON provider or facility cannot bill individual for payment amount greater than in-network cost sharing

(45 CFR 149.410 – 420)

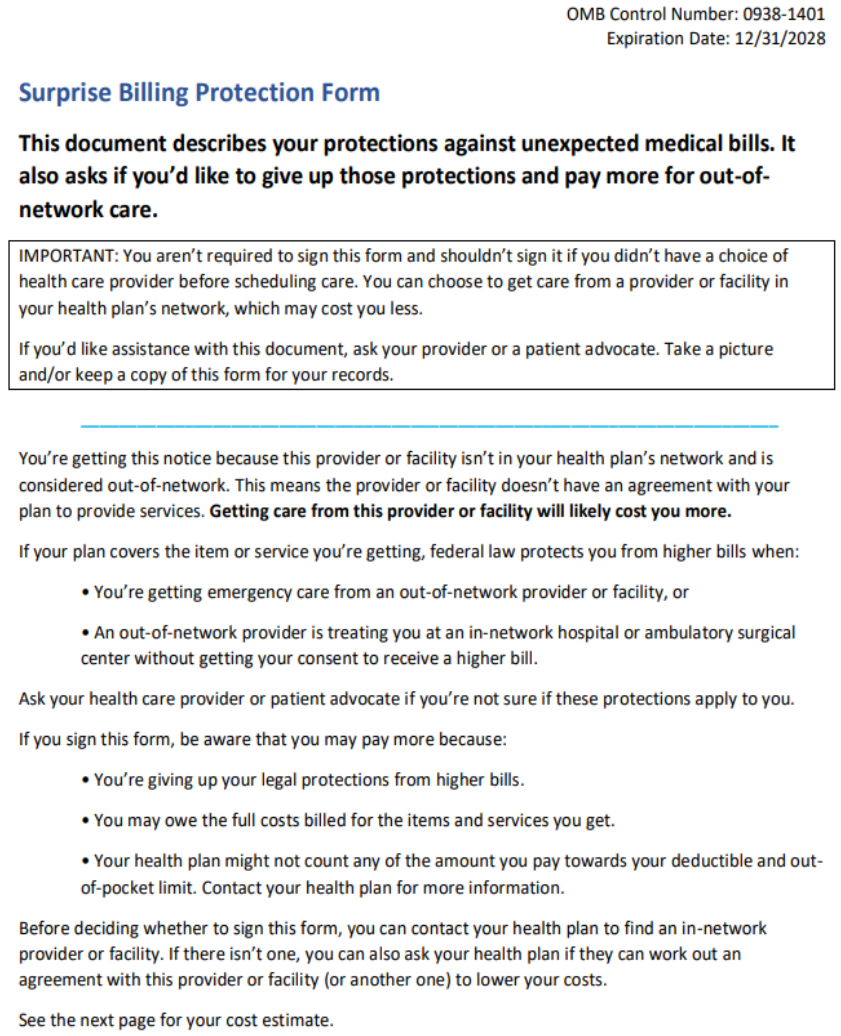
Subpart E: Provider / Facility
Prohibitions

Non-Emergency Services Exception

- May balance bill if
  - Items or services do not meet definition of ancillary services
  - Another in-network provider can deliver the items or services at the in-network facility
  - Notice and consent

(45 CFR 149.410 – 420)

Notice and Consent



OMB Control Number: 0938-1401
Expiration Date: 12/31/2028

Surprise Billing Protection Form

This document describes your protections against unexpected medical bills. It also asks if you'd 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 before scheduling 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 and is considered out-of-network. This means the provider or facility doesn't have an agreement with your plan to provide services. **Getting care from this provider or facility will likely cost you more.**

If your plan covers the item or service you're getting, federal law protects you from higher bills when:

- You're getting emergency care from an out-of-network provider or facility, or
- An out-of-network provider is treating you at an in-network hospital or ambulatory surgical center without getting your consent to receive a higher bill.

Ask your health care provider or patient advocate if you're not sure if these protections apply to you.

If you sign this form, be aware that you may pay more because:

- You're giving up your legal protections from higher bills.
- You may owe the full costs billed for the items and services you get.
- 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.

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, you can also ask your health plan if they can work out an agreement with this provider or facility (or another one) to lower your costs.

See the next page for your cost estimate.

- Notice and consent must contain certain info
  - Provider is OON
  - Good faith estimate of charges
  - Notice is not a contract
  - Consent is optional
  - Patient may receive care from in-network provider
  - Info about services

- OON provider/facility must notify insurer if obtain consent to balance bill

(45 CFR 149.410 – 4 20)

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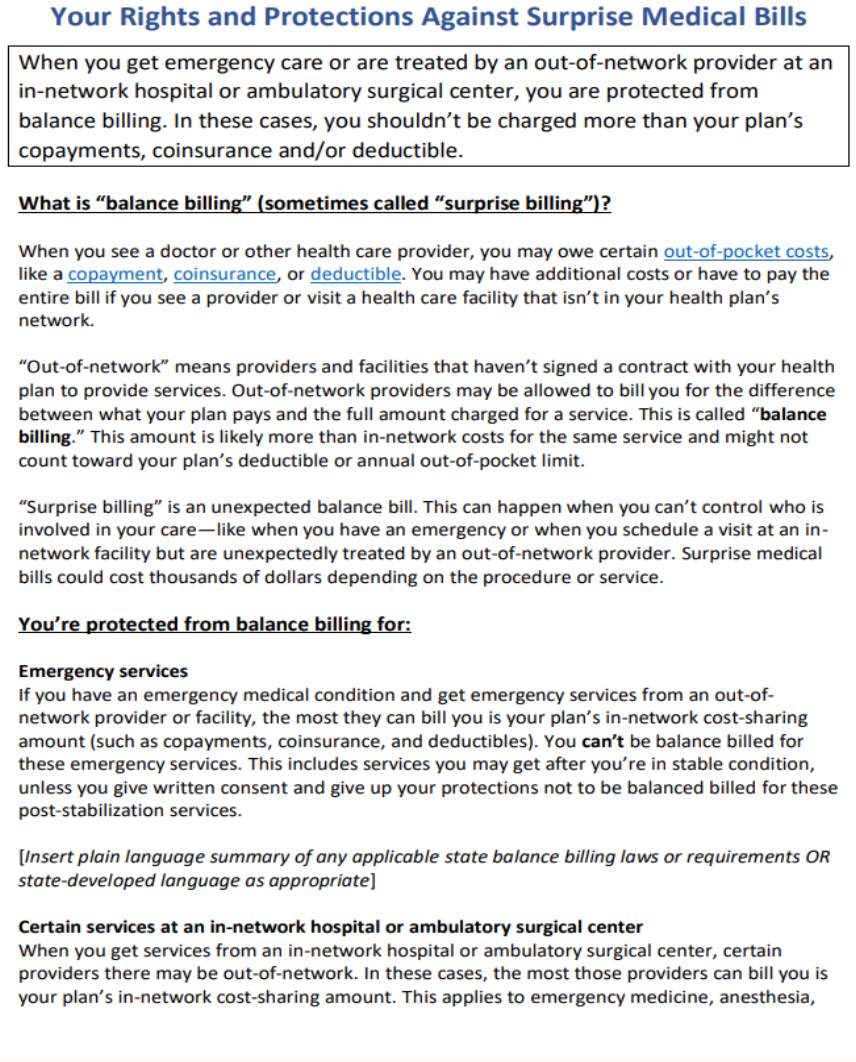
Notice and Consent

- Notice and Consent exception does not apply to certain services, including:
  - Unforeseen, urgent medical needs that arise at time services rendered
  - Pre-stabilization emergency services
  - Ancillary services (e.g., anesthesiology, pathology, radiology, neonatology; assistant surgeons, hospitalists, and intensivists; diagnostic services, including radiology and labs)
  - Items or services provided by OON provider at a in-network facility if there is not an in-network provider who can furnish them
  - State law bans

(45 CFR 149.410 – 420)

Provider / Facility Disclosure Requirements



Your Rights and Protections Against Surprise Medical Bills

When you get emergency care or are treated by an out-of-network provider at an in-network hospital or ambulatory surgical center, you are protected from balance billing. In these cases, you shouldn't be charged more than your plan's copayments, coinsurance and/or deductible.

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, like a copayment, coinsurance, or deductible. You may have additional 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" means providers and facilities that haven't signed a contract with your health plan to provide services. Out-of-network providers may be allowed to bill you for the difference between what your plan pays 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 plan's deductible or 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. Surprise medical bills could cost thousands of dollars depending on the procedure or service.

You're 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 they can bill you is your plan's in-network cost-sharing amount (such as copayments, coinsurance, and deductibles). 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 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 can bill you is your plan's in-network cost-sharing amount. This applies to emergency medicine, anesthesia,

- Facilities and providers to which the balance bill rule applies must:
  - Post notice on website
  - Post notice on sign
  - Give notice to patients in person, mail, or e-mail as determined by patient

(45 CFR 149.430)

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Air Ambulances

- OON air ambulance provider renders services to a covered person, provider may not bill patient more than cost-sharing amount that would apply to an in-network provider
- No exception for notice and consent

➢*May still bill and recover from plan or insurer for covered services*

➢*May still bill self-pay patients*

(45 CFR 149.440)

Concept Crossover:

QPA

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Qualifying Payment Amount

- QPA: Generally, the plan or issuer's median contracted rate for the item or service in the geographic market
- QPA serves as benchmark for:
  - Patient cost-sharing calculations
  - Federal IDR process consideration
  - Initial payment baseline

QPA: Plans / Issuers

- QPA: established at 49 CFR 149.140
- Many definitions within; complicated
- Plan Disclosure Requirements E.g.:
  - Must share QPA with initial payment or denial
  - Must disclose upon provider/facility request

- *Texas Medical Association lawsuits (4!)*
- TMA challenged how QPA was used in various lawsuits
  - Weight of QPA
  - Calculation of QPA
- Expect new FAQs!
  - 8/2026: may not include ghost rates and must include bonus and incentive payments

QPA: Provider / Facility

- The amount to which cost-sharing applies (i.e., the "recognized amount") is determined in descending order of the following:
  - Amount determined by applicable All-Payer Model Agreement under the SSA; or
  - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
  - If neither of the foregoing apply, the lesser amount of either the billed charge or the QPA

(45 CFR 149.140(a)(16); 45 CFR 149.140(c); 45 CFR 149.20)

QPA Disclosure Requirements Expansion

- Where the recognized amount is the QPA or the billed charge, expanded disclosures are now required with each initial payment or notice of denial
    1. Open negotiation notice
    2. Federal IDR process notice
    3. Plan/issuer identification
- Effective August 3, 2026

3. Federal IDR Process & Changes

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Final Rule

- Published June 4, 2026 (91 Fed. Reg. 33900); Effective August 3, 2026
- Most comprehensive revision of Federal IDR Process
- Aimed to address:
  - Volume of IDR disputes
  - Reduce backlog
  - Increase transparency and information sharing
- Various effective dates

  * = stay tuned

Plan & Issuer Registration Requirement

- Who must register?
  - Self-insured group health plans
  - FEHB Program carriers
  - Health insurance issuers
  - TPAS may register on behalf of plans
    - Plan/issuer remains responsible

- Required information
  - Legal business name (and plan sponsor)
  - Entity type
  - State of coverage/licensure
  - Contact info
  - Opt-in elections for State /APM
  - Identifiers (HIOS, EIN)
  - Additional identifying information

Plan & Issuer Reporting Requirement

- Deadlines
  - Certify annually
  - Report changes within 30 calendar days
  - Completed 90 business days after guidance announcing IDR Gateway functionality

September 15, 2026

Sign Up Now for the IDR Gateway!

Today, account creation for the Independent Dispute Resolution (IDR) Gateway opens for participants in the Federal IDR process. Create an account, sign in to the IDR Gateway, and join an organization.

IDR Gateway

In late 2026, the Federal Independent Dispute Resolution (IDR) process will transition from single-use web forms to the new IDR Gateway, which will provide a secure, centralized platform that parties can use to manage disputes. IDR Gateway users will be able to:

- Start and respond to disputes.
- Access dispute dashboards and reports associated with their organization.
- Track dispute information, including disputes assigned to a certified IDR entity.
- Monitor assigned disputes by process phase.
- Review notifications regarding dispute activity.

The IDR Gateway includes important new security features, including identity verification processes and protocols that permit only U.S.-based users to access the Federal IDR process.

Who Should Sign Up?

Organizations and individuals that process disputes, represent parties, or submit IDR web forms in the current Federal IDR process must sign up to manage disputes in the IDR Gateway. If a party uses a third-party administrator or another organization to process disputes, the party does not need to sign up for the IDR Gateway but must ensure the third-party administrator or organization responsible for managing dispute activities signs up for an IDR Gateway account.

For a limited period, parties can continue to submit web forms without signing in to the IDR Gateway. The web forms will no longer be available outside the IDR Gateway after January 15, 2026, except for the "Notice of IDR Initiation – Resubmission" web form. To continue using the Federal IDR process, sign up for the IDR Gateway.

To sign up for the IDR Gateway:

1. Navigate to the IDR Gateway Access page and select the Sign Up button.
2. Create an account and verify your identity using a credential service provider. If you already have an account with a credential service provider, sign in to the IDR Gateway using your existing credentials.
3. Check your email for confirmation that you successfully created your account.
4. Sign in to the IDR Gateway to finish setting up your profile.

Questions?

Email IDRGatewayHelp@cms.hhs.gov or call 1-800-985-3059.

For more information about the IDR Gateway, refer to the IDR Gateway page.

Standardized Communication Codes*

- CARCs and RARCs Required
  - Plans and issuers must use
    - Claim Adjusted Reason Codes
    - Remittance Advice Remark Codes
  - All remittance advice sent to entities lacking contractual relationship with plan
  - Must indicate whether claim is subject to NSA
- Addresses communication gaps

Starting IDR Process: OON Payment to Providers

- Total amount paid to OON provider/facility, including patient cost-sharing amount =
  - Amount determined by applicable All-Payer Model Agreement under the SSA; or
  - If there is no applicable All-Payer Model Agreement, amount determined by state law; or
  - If neither of the foregoing apply, an amount agreed upon by the payer and provider/facility during 30-day "open negotiation" period; or
  - If plan and provider/facility cannot agree, amount determined through IDR process

Open Negotiation

- Within 30 days after receipt of partial payment or denial, send notice starting open negotiating period
  - Notice must contain required info
- Attempt to negotiate resolution during 30-day negotiation period

(45 CFR 149.510(b))

Open Negotiation Process Reforms*

- Initiation
  - Written notice through IDR portal to other party and secretary
  - 30-business-day period beginning only when notice and remittance advice documentation are submitted
  - Notice must include certain required elements
    - Detailed claim and service info
    - QPA
    - IDR Registration #s
- Mandatory Response
  - Written response due by 15th business day of open negotiation period
  - Must confirm or correct payment and QPA information
  - Identify any inaccuracies
  - State whether item/service is subject to IDR
  - Provide supporting documentation

IDR Gateway?

Q4. Will open negotiation be in the Gateway?

A4: The initial rollout of the IDR Gateway does not include functions to support open negotiation. As required in the Federal IDR Operations Final Rule, open negotiation functions will be required within the Gateway once those features are available. The Departments will provide notice and technical assistance in advance of the open negotiation features becoming available.

IDR Initiation

- If cannot agree during 30-day open negotiation period, request IDR by filing notice <u>within 4 business days</u> after 30-day open negotiation period ends

https://nsa-idr cms gov/paymentdisputes/s/

(45 CFR 149.510(b))

Notice of IDR Initiation

OMB Control Number: 1210-0169 Expiration Date: 11/30/202

Disputing parties will generally have **4 business days** from the conclusion of their open negotiation period to submit a Notice of IDR Initiation, unless the dispute qualifies for an exception, such as the dispute being subject to the 90-day cooling off period, the dispute having received prior approval for an extension, or a certified IDR entity has requested the party to resubmit the dispute.

IMPORTANT: The administrative fee is $15.00.

NOTE: Once you complete the Notice of IDR Initiation, download a copy and send the Notice of IDR Initiation PDF to the Non-Initiating Party.

REMINDER: You must complete and submit the form in a single session. For security reasons and protection of personal data, your session will time out after 60 minutes of inactivity.

Use this form if you participated in an open negotiation period that has expired without an agreement for an out-of-network total payment amount for the qualified IDR item or service.

You can start the Federal Independent Dispute Resolution (IDR) process within 4 business days after the end of the 30-business-day open negotiation period if a determination of the total payment for the qualified IDR item(s) or service(s), including cost-sharing, wasn't reached.

You will need to **provide information for both parties involved** in the dispute.

The parties can still reach an agreement on a payment amount during the IDR process, but you must reach an agreement before the certified independent dispute resolution entity determines the payment amount.

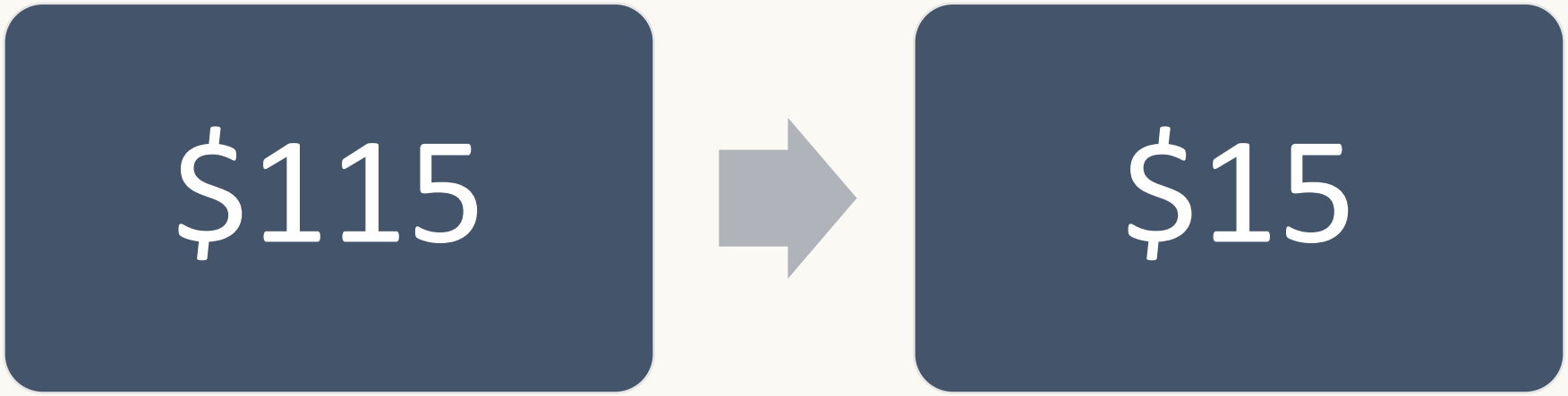
Review the IDR State list to determine which states will have processes that apply to payment determinations for the items, services, and parties involved. FEHB plans are subject to the Federal IDR process unless OPM contracts with FEHB carriers to include terms that adopt state law as governing for this purpose.

Need Help? Contact FederalIDRQuestions@cms.hhs.gov if you have any questions about this form.

Before starting:

You may need to provide information by uploading separate documents. The total file size limit for all uploaded documents is 500MB. Be sure your files meet this limitation.

Administrative Fee Reduction



- Per party per dispute fee reduced to $15 on or after June 11, 2026
- Aimed to increase accessibility
- Must be paid no later than date a party submit its offer
- **Failure to pay is treated as the offer is not received**

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IDR Initiation and Response Requirements*

- Initiation Notice
  - Content similar to open negotiation notice
  - Attestation that I/S is eligible for IDR process
  - Sent to non-initiation party and Secretary
- Response
  - Confirm or correct initial payment amount, QPA, cost-sharing, remittance advance
  - Dispute any other acts
  - Confirm or dispute eligibility
- Goal: surface eligibility disputes early and create standardized process for IDR

Revised Batching Rules (11/1/26)

- "Same or similar item or services" replaced with "treatment of a similar condition" standard May be batched if in 1 of 3 categories:
    1. Single patient / single encounter; billing on same claim form
    2. Same service code or comparable code
    3. Specialty-specific CPT range (e.g., anesthesiology, radiology, pathology, laboratory)
- Hard cap of 50 qualified IDR items per batch
- Bundled payment arrangements maybe submitted and considered as a single payment determination with a single fee

IDR Entity Selection

- Within 3 business days after IDR initiated, the parties may agree or object to the IDR entity
  - E.g., conflict of interest
- Within 4 days after IDR initiated, initiating party must notify HHS of IDR entity if parties agreed
- Within 4 days after IDR initiated, receiving party must submit any objections to IDR process
- Within 6 days after IDR initiated, if parties fail to agree to IDR entity, HHS will appoint the IDR entity
  - IDR entity's fees may be greater than if selected by parties
- If parties agree on OON rate while IDR is pending, they must notify HHS within 3 days after agreement
- IDR amounts may be submitted in batches or bundled payment arrangements *

(45 CFR 149.510(c))

Future IDR Entity Selection*

- Non-initiating party: 3 business days to agree or object to preferred IDR entity
- If agreed or no response: Initiating party's choice is deemed selected on 3rd business day
- If objection: initiating party may agree or object to the alternative via notice through portal
  - Timing rules vary at this stage
- Distinction between preliminary and final selection
  - Finalized only after conflict-of-interest attestation and Secretary notification to parties in IDR
- 5 business days after final selection: determine if I/S is eligible for IDR process
  - If ineligible, dispute closes

IDR Process

- Within 10 days after IDR entity selected, each party submits OON rate offer
  - Both in dollar amount and % of QPA
  - Info requested by IDR entity
  - Additional info as appropriate:
    - Size of practice or facility (i.e., number of employees)
    - Practice specialty
    - QPA for the applicable year for the same or similar item or service
  - Additional info the party believes is appropriate
- Both parties submit IDR entity's fee
  - Winner receives a refund

(45 CFR 149.510(c)(4))

IDR Process

- Within 30 days after IDR entity selected, IDR issues written decision selecting one of the offers based on:
  - QPA for applicable year for same or similar item/service
  - Additional info submitted by a party parties relating to:
    - Provider's training, experience, quality, outcomes
    - Market share
    - Acuity of patient or complexity of item/service
    - Facility's teaching status, case mix scope of services
    - Prior network agreements between the parties
    - Other info relevant to offer submitted by a party
  - Additional info submitted by parties in response to IDR entity request
  - May not consider usual/customary charges, billed charges, or public payer rates

(45 CFR 149.510(c))

IDR Process

- As originally drafted, the IDR process was skewed heavily in favor of the QPA
- *Remember TMA III:* invalidated QPA methodology and bias; may not include ghost rates and must include bonus and incentive payments
  - HHS issued a series of FAQs and other guidance addressing effects of *TMA* decisions
  - Depts will exercise enforcement discretion in evaluating parties' methodologies
- CMS on 8/13/26: "reviewing [TMA III] opinion and judgment and anticipate issuing guidance shortly The Federal [IDR] process remains operational "

IDR Decision

- Effect of IDR decision:
  - Binding on parties absent fraud or intentional misrepresentation of a material fact
  - Not subject to judicial review
  - Party who initiated IDR may not initiate another IDR involving same party and same or similar claims for 90 days
- Within 30 days of decision:
  - Loser pays balance due other party
  - Loser remains responsible for IDR entity fee
  - Winner's prepaid fee is refunded
- In 6/25, HHS issued guidance on reopening IDR process to address errors identified after dispute closure (See https://www cms.gov/files/document/idr-ta-errors-after-dispute-closure.pdf)

(45 CFR 149.510(c)(4)(vii) – (ix))

Withdrawal Methods

Type	Mechanics
Mutual Withdrawal*	Initiating party notifies Departments and IDR Entity via Portal
Initiating Party Request*	Initiating party notifies all parties Non-initiating party has 5 business days to agree or object If fail to respond, deemed agreed and withdrawn
Eligibility Cannot be Determined (11/1/26)	IDR Entity withdraws dispute when eligibility cannot be determined (e.g., both nonresponsive)
Payment Determination Cannot be Made (11/1/26)	IDR Entity withdraws dispute when payment determination cannot be made (e.g., failure to submit offer)

- No unilateral withdrawal by initiating party
- Rationale for withdrawal is not required
- Fee implications

Extenuating Circumstances (11/1/26)

- Extension Requests
  - Either party or certified IDR entity may request extensions through portal
  - Existing grounds retained
  - New category: system-wide delays (dispute volume)
  - Secretary must post public notice of any extension
- Deadline-Shifting Rules
  - If eligibility determination period is extended:
    - Offer and payment determination deadlines run from date eligibility is determined
  - If another Federal IDR timeframe is extended
    - Subsequent deadlines run from completion that process step

Implementation Timeline

Federal Independent Dispute Resolution (IDR) Operations Final Rules Implementation Timeline Guide for Certified IDR Entities and Disputing Parties

August 7, 2026

Topic: Federal IDR Operations Final Rules Implementation Timeline

https://www cms gov/files/document/federal-idr-operations-implementation-timeline.pdf

Notices

The Departments of Health and Human Services, Labor, and the Treasury (the Departments) will post important information regarding the No Surprises Act to this page. Please check back frequently for updates.

https://www cms gov/initiatives/no-surprise-billing/overview/notices

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4. Enforcement Landscape

No Surprise Billing Rules: Penalties

- Reduced or denied payment
  - Insured Patient: limited or denied payment
    - Unable to balance bill patient
    - Limited OON rate from payers
  - Self-Pay Patient: limited or denied payment under the PPDR process
- State enforcement
  - May vary by state
- If state fails to enforce, HHS may impose:
  - Corrective action plan
  - $10,000 civil penalty

(42 USC 300gg-134(b); 45 CFR 150.101(b)(3), 150.501(a), and 150.513(a))

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IDR Determinations

- Regulations are clear that IDR determinations are binding
  - 42 CFR 149.510(c)(4)(vii)
- Payment obligations are imposed following IDR determination
- What happens if a plan doesn't pay?

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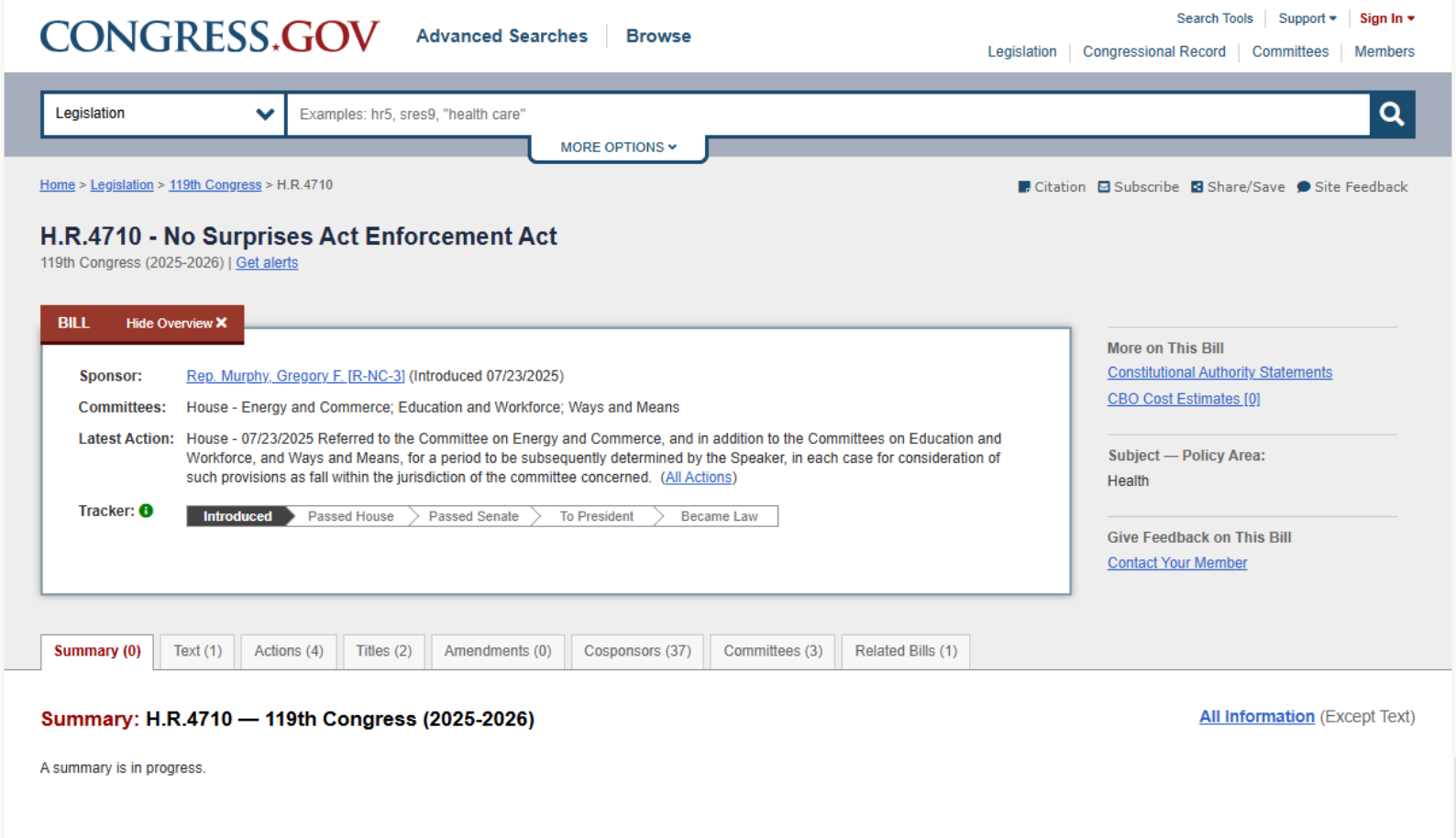
Circuit Split – Private Right of Action

No Private Right of Action	Implied Right of Action
Guardian Flight LLC v Health Care Serv Corp (5th Cir. 2025) (cert. denied): • NSA's text and structure do not support express or implied private enforcement • Judicial involvement limited to FAA vacatur grounds	Guardian Flight LLC v Aetna Life Ins (D. Conn. 2025)
• Worldwide Aircraft Services inc v Worldwide Insurance Services (M.D. Fla. 2025)	PHI Health LLV v Optum Choice Inc (D. Md. 2026)
• East Coast Advanced Plastic Surgery LLC v Cigna Health and Life Ins Co (S.D.N.Y. 2025)	

Alternatives?
- ERISA; still subject to different interpretations

Potential Legislation



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Legislation | Examples: hr5, sres9, "health care"

MORE OPTIONS

Home > Legislation > 119th Congress > H.R.4710

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H.R.4710 - No Surprises Act Enforcement Act

119th Congress (2025-2026) | Get alerts

BILL | Hide Overview

Sponsor: Rep. Murphy, Gregory F. [R-NC-3] (Introduced 07/23/2025)

Committees: House - Energy and Commerce; Education and Workforce; Ways and Means

Latest Action: House - 07/23/2025 Referred to the Committee on Energy and Commerce, and in addition to the Committees on Education and Workforce, and Ways and Means, for a period to be subsequently determined by the Speaker, in each case for consideration of such provisions as fall within the jurisdiction of the committee concerned. (All Actions)

Tracker: Introduced > Passed House > Passed Senate > To President > Became Law

More on This Bill

Constitutional Authority Statements

CBO Cost Estimates [0]

Subject — Policy Area:

Health

Give Feedback on This Bill

Contact Your Member

Summary (0) | Text (1) | Actions (4) | Titles (2) | Amendments (0) | Cosponsors (37) | Committees (3) | Related Bills (1)

Summary: H.R.4710 — 119th Congress (2025-2026)

All Information (Except Text)

A summary is in progress.

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Complaint Process

- Complainant may file complaint with HHS for violations of the No Surprises Billing Rule
- HHS will review the complaint and may request additional information
- HHS may refer complaints against payers to CMS enforcement process under 45 CFR part 150
- HHS will make reasonable attempts to notify the complainant of the resolution

(45 CFR 149.450)

Likely Enforcement Pathway

1. Evaluate precedent within jurisdiction
   A. Could use as bargaining chip
      File complaint with HHS
   B. Pursue administrative remedies
2. Seek judicial review after exhaustion

- Practical realities
  - Well-documented challenges in administering volume of IDR disputes
  - Administrative complaint process may not produce swift results
  - Continued litigation could contribute to split in interpretations

5. Self-Pay / Uninsured Protections

Subpart E: Uninsured or Self-Pay Patients

- Good faith estimate
- Patient-Provider Dispute Resolution ("PPDR") process

Inquire if Patient is Self-Pay

- Convening provider/facility must determine if an individual is uninsured or a self-pay (collectively "self-pay") individual:
  - Ask if the patient is covered by a group plan, insurance or a federal healthcare program *
  - If patient has coverage, ask if patient wants to have the claim submitted to the payer for the primary item or service
  - If self-pay,* inform the patient that they may obtain a good faith estimate of expected charges upon:
    - Scheduling the item or service, or
    - Upon request

(45 CFR 149.610(b)(1))

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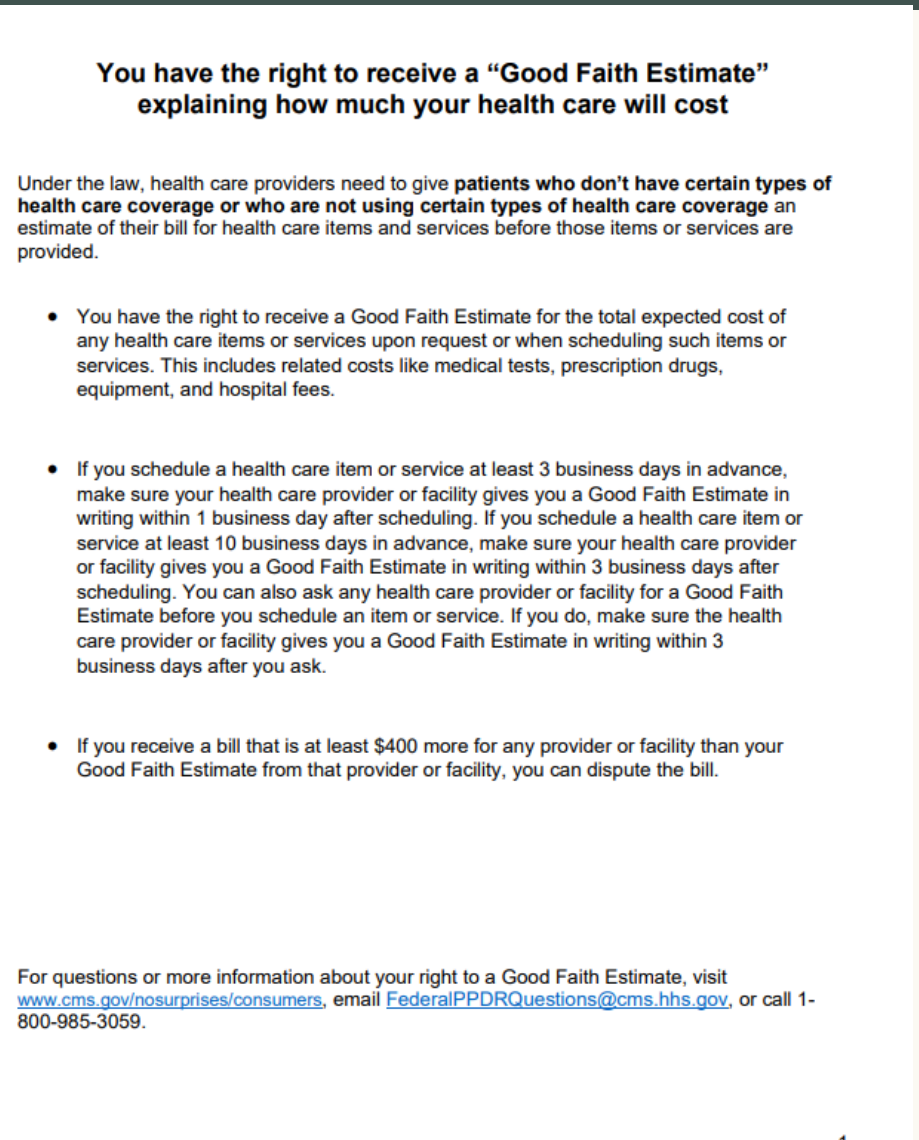
Notice of Good Faith Estimate



You have the right to receive a "Good Faith Estimate" explaining how much your health care will cost

Under the law, health care providers need to give **patients who don't have certain types of health care coverage or who are not using certain types of health care coverage** an estimate of their bill for health care items and services before those items or services are provided.

- You have the right to receive a Good Faith Estimate for the total expected cost of any health care items or services upon request or when scheduling such items or services. This includes related costs like medical tests, prescription drugs, equipment, and hospital fees.
- If you schedule a health care item or service at least 3 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 1 business day after scheduling. If you schedule a health care item or service at least 10 business days in advance, make sure your health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after scheduling. You can also ask any health care provider or facility for a Good Faith Estimate before you schedule an item or service. If you do, make sure the health care provider or facility gives you a Good Faith Estimate in writing within 3 business days after you ask.
- If you receive a bill that is at least $400 more for any provider or facility than your Good Faith Estimate from that provider or facility, you can dispute the bill.

For questions or more information about your right to a Good Faith Estimate, visit www.cms.gov/nosurprises/consumers, email FederalPPDRQuestions@cms.hhs.gov, or call 1-800-985-3059.

- Convening provider/facility must inform self-pay patients about right to good faith estimate by:
  - Written notice prominently displayed
  - On provider/facility's website;
  - In its office; and
  - Onsite where scheduling or questions about cost of items or services occur
- Orally inform patient when scheduling item or service or when patient asks about cost of items or services
- Notice must be made available in accessible formats and the language spoken by the patient

(45 CFR 149.610(b)(1))

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Provide Good Faith Estimate

- If self-pay person:
  - Requests a good faith estimate (including inquiry or discussion about costs), or
  - Upon scheduling a primary item or service,

  convening facility must:
  - Within 1 business day, ask co-providers/facilities to submit good faith estimate to the convening provider/facility by due date *
  - Timely provide written good faith estimate to the patient

** Co-provider enforcement discretion still in effect pending rulemaking*

(45 CFR 149.610(b)(1))

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Provide Good Faith Estimate

Schedule / Request In Advance	Provision of GFE
Scheduled at least 3 days in advance	1 business day after scheduling
Scheduled at least 10 days in advance	3 business days after date of scheduling
Requests GFE	3 business days after date of request
Scheduled less than 3 days in advance	No GFE

- "**For items or services scheduled fewer than 3 business days before the date of service, a GFE is not required** For example, a GFE is not required in emergency situations, walk-in appointments, or where care is scheduled 1 or 2 business days in advance "

(https://www cms gov/files/document/fact-sheet-what-is-considered-health-insurance pdf)

(45 CFR 149.610(b)(1))

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Provide Good Faith Estimate

- Convening facility may issue a single good faith estimate for recurring primary items/services if:
  - Such good faith estimate includes in clear manner the scope of the recurring items/services (e g , timeframes, frequency, total number, etc)
  - Scope of good faith estimate may not exceed 12 months
  - If good recurring items/service extend beyond 12 months, must provide new good faith estimate

(45 CFR 149.610(b)(1))

Provide Good Faith Estimate

- If convening providers/facilities or co-providers/facilities listed in good faith estimate change less than 1 business day before the item/service is scheduled to be provided:
  - Replacement provider/facility must accept the existing good faith estimate as its good faith estimate
  - Replacement providers/facilities are bound by the existing good faith estimate

➢ *Replacement providers should review good faith estimate and provide new good faith estimate if there is time*

(45 CFR 149.610(b)(1)(viii) – (2)(iii))

Content of Good Faith Estimate

[NAME OF CONVENING PROVIDER OR CONVENING FACILITY]

Good Faith Estimate for Health Care Items and Services

Patient			
Patient First Name	Middle Name		Last Name
Patient Date of Birth:	_____/_____/_____		
Account Number (last four digits) (optional):			
Patient Mailing Address, Phone Number, and Email Address			
Street or PO Box			Apartment
City	State		ZIP Code
Phone			
Email Address			
Patient's Contact Preference:	[ ] By mail	[ ] By email	[ ] By phone
Patient Diagnosis (if determined)			
Primary Service or Item Requested/Scheduled			
Patient Primary Diagnosis		Primary Diagnosis Code	
Patient Secondary Diagnosis		Secondary Diagnosis Code	
If scheduled, list the date(s) the Primary Service or Item will be provided: [ ] Check this box if this service or item is not yet scheduled			

- Good faith estimate must include required info:
  - Patient name and birthdate;
  - Items and services by codes and charges
  - Discounts or adjustments
  - Name, NPI, TIN of co-provider/facility,
  - Location where each item/service is provided;
  - List of items/services that will require separate scheduling; Disclaimers

➢ *Make sure good faith estimate is accurate and complete*

(45 CFR 149.610(c))

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Delivery of Good Faith Estimate

- Must be in writing and given in manner requested by patient:
  - Paper;
  - Electronically in form so patient may save and print;
  - Orally if requested but still must provide in writing
- Must provide in a manner understandable to the patient, considering:
  - Vision and hearing;
  - Language limitations, including limited English proficiency;
  - Communication needs of underserved populations;
  - Health literacy

➢*May need interpreters, translators, auxiliary aids*

(45 CFR 149.610(e); 86 FR 56021)

Maintain Good Faith Estimate

- Good faith estimate is part of the patient's medical record and must be maintained in same manner as medical record
- Must keep for 6 years and provide to patient if requested

➢ *Need to have good faith estimate available if there is claim:*

- *PPDR*
- *Dispute over collections*

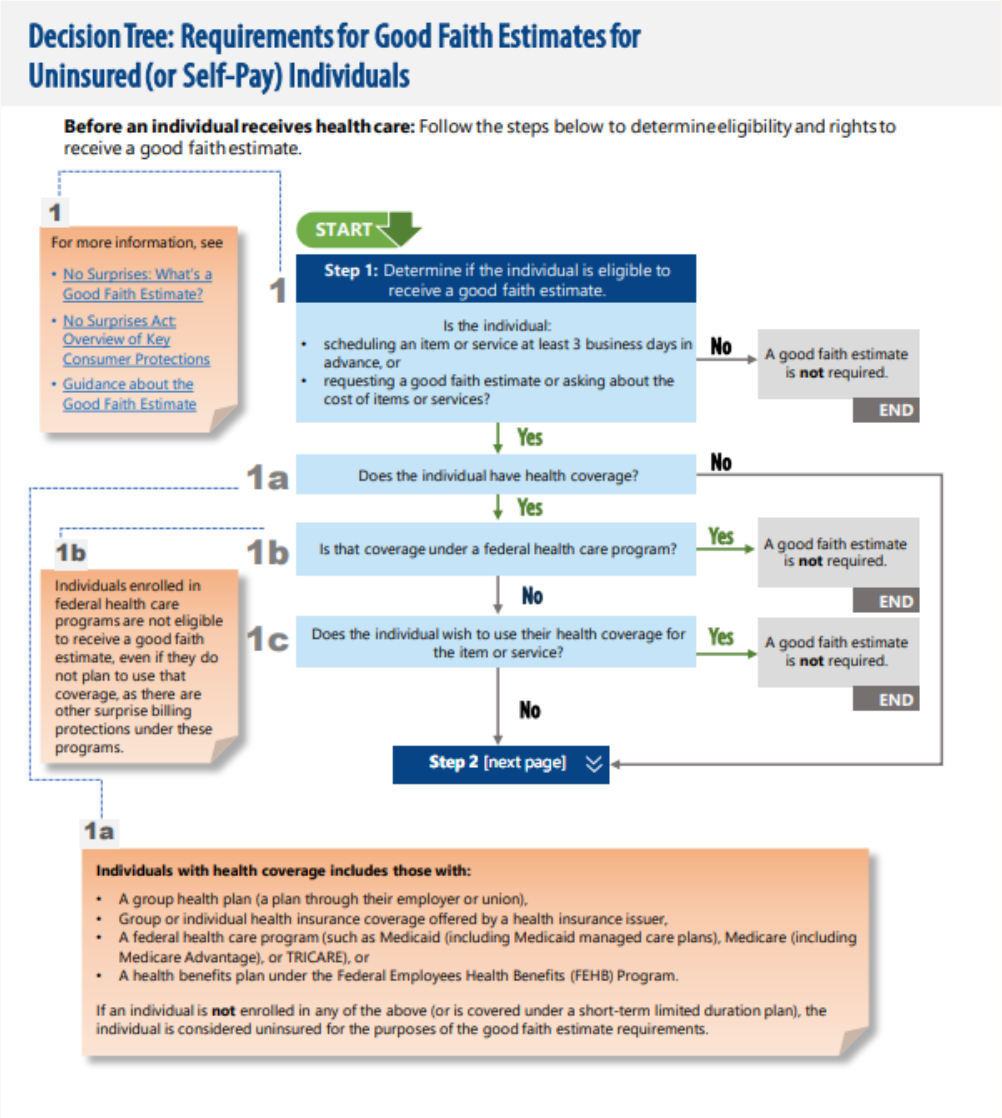
(45 CFR 149.610(f)(1) – (2))

Errors

- Errors ≠ noncompliance so long as:
  - Acted in good faith with reasonable due diligence; and
  - Correct info as soon as practicable
- Good faith reliance on other providers ≠ noncompliance so long as:
  - Did not know and should not know of error; and
  - Correct info as soon as practicable
- But still bound by PPDR if actual charges are substantially in excess of good faith estimate

(45 CFR 149.610(f)(3) – (4))

Good Faith Estimate Guidance



- Decision Tree for GFE, see https://www cms gov/files/document/nsa-gfe-decision-tree.pdf

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Self-Pay Patients: PPDR Process

1. Trigger: Total billed charges for a listed provider/facility exceed GFE by $400+
   - Calculated per provider, not across all providers on GFE
   - Includes I/S not listed on GFE if billed by same provider
2. Patient initiates within 120 days of receiving bill, notify HHS and pay $25 fee
3. Provider obligations while PPDR pending
   - Cannot move bill to collections or threaten to do so
   - Cease collection efforts
   - Suspend late fees
   - Cannot take retribution against patient
4. Provider submission: within 10 days, submit GFE, billed charges, and documentation showing medical necessity and any unforeseen circumstances (standard)
5. PPDR decision within 30 days

(45 CFR 149.620(a)(2)(iii))

Self-Pay Patients: PPDR Process

Scenario	Provider Proves Medical Necessity or Unforeseeable?	Patient pays
Billed charge ON estimate; billed < estimate	N/A	Billed charge
Billed charge ON estimate; Billed > estimate	No	Expected charged from GFE
Billed charge ON estimate; Billed > estimate	Yes	Lesser of: billed charge; expected charge; or median rate
Billed charge NOT on estimate	No	$0
Billed charge NOT on estimate	Yes	Lesser of: billed charge; or median rate

6. Compliance

Coordination with State Laws

- May need to coordinate the No Surprise Billing Rules with state laws, e.g.,
  - Notice concerning fees
  - Fees that may be charged
  - Dispute resolution process
  - Other?
- If and to the extent state laws provide less protection to patients than the No Surprise Billing Rules, apply the No Surprise Billing Rules
- If and to the extent state laws provide more protection to patients than the No Surprise Billing Rules defer to state law

(45 CFR 149.620(h))

Immediate Action Items for Plans / Issuers

- ❑ Register in IDR gateway (mandatory by Jan 15, 2027)
- ❑ Develop mechanisms for reporting requirements
- ❑ Implement new CARC/RARC codes on remittance advice
- ❑ Implement expanded QPA disclosures
- ❑ Monitor TMA III decision for QPA calculation requirements and FAQs

Immediate Action Items for Provider / Facilities

- ❑ Register in IDR gateway (or ensure third party representative has signed up)
- ❑ Compile checklist of documents for initiation notice submissions
- ❑ Review current batching practices for compliance

Providers / Facilities Generalized Checklist

Balance Billing & Notice and Consent

- ❑Use OMB-approved Surprise Billing Protect Forms
- ❑Verify notice and consent only used when permitted
  - ❑Identify scenarios where exceptions come into play
- ❑Have processes for notification of insurers when consent to balance bill is obtained

Disclosure requirements

- ❑Post required notices in required locations
- ❑Document process for provision of disclosures to patients
- ❑Have alternative formats available for accessibility

Providers / Facilities Generalized Checklist

GFE

- ❑ Review processes for following GFE provision steps
  - ❑ Inquiry
  - ❑ Inform
  - ❑ Delivery
  - ❑ Timeline
  - ❑ Maintenance

Disclosure requirements

- ❑ Post required notices in required locations
- ❑ Have alternative formats available for accessibility

PPDR

- ❑ Establish process for PPDR initiation notices
- ❑ Establish recordkeeping mechanisms to support medical necessity and unforeseen circumstances

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https://www cms gov/nosurprises

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Ending Surprise Medical Bills

Learn how providers, facilities, plans and issuers can comply with surprise billing protections and resolve

Thank You!

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