No Surprises Act: Division BB, Title I, of CAA

Topline Messages

* CMS has released two interim final rules (IFR) and one interim final rule with comment (IFC) with regard to the No Surprises Act (NSA). Only the two IFRs, Requirements Related to Surprise Billing Parts I and II, could impact behavioral health providers.
* The scope of the NSA includes mental health and substance use disorder as emergency services. However, **the impact on behavioral health providers may be narrow, as emergency mental health services are generally rare**. **While** **Parts I and II of CMS’s IFRs can apply to nonemergency services, outpatient mental health providers are not covered under definitions of nonemergency providers in the NSA and are not subjected to the NSA and its regulations**.
  + **Part I** — This rule bans balance billing, among other items. For this rule to apply, the behavioral health provider and/ or the emergency facility may be out-of-network for the patient. According to CMS, emergency medical conditions can include a mental health condition. However, the ban on balance billing does *not* apply if a patient consents to treatment by an out-of-network provider, which CMS notes can vary depending on the mental condition of the patient. While not included in the IFR, the NSA allows HHS to waive consent forms in the future, and thus ban balance billing, for emergency mental health services, which federal officials have previously considered.
  + **Part II** — This rule covers a dispute resolution process and may encompass behavioral health providers who are furnishing services as an out-of-network provider, and/or at an out-of-network hospital. This rule could also apply to out-of-network behavioral health providers administering non-emergency services that occur at an in-network facility.

Background on Each Rule

Requirements Related to Surprise Billing; Part I ([TRP analysis](https://myemail.constantcontact.com/CMS-Releases-First-Interim-Final-Rule-on-Surprise-Billing.html?soid=1130896595582&aid=72H1jWk0QgU); [rule](https://www.cms.gov/files/document/cms-9909-ifc-surprise-billing-disclaimer-50.pdf), [fact sheet](https://www.cms.gov/newsroom/fact-sheets/what-you-need-know-about-biden-harris-administrations-actions-prevent-surprise-billing), [additional fact sheet](https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-i-interim-final-rule-comment-period), [press release](https://www.hhs.gov/about/news/2021/07/01/hhs-announces-rule-to-protect-consumers-from-surprise-medical-bills.html))

* This rule applies to out-of-network **emergency services** and **post-stabilization services** (out-of-network facility and/orout-of-network provider), and **non-emergency services performed by nonparticipating providers at participating health care facilities**.
* This package of rules includes five provisions of the No Surprises Act (NSA). The characteristics of these interim final rules (IFRs) include:
  + Application of the NSA to group health plans, health insurance issuers, and the Federal Employee Health Benefits (FEHB) Program with respect to banning balance billing, out-of-network cost sharing for emergency services and, non-emergency services furnished by nonparticipating providers within participating facilities;
  + Prohibiting nonparticipating providers and facilities from balance billing in certain situations and permit it in some cases;
  + Require certain facilities and providers to disclose patient protections against balance billing; and
  + Create a complaint process for violations relating to balance billing and out-of-network cost sharing.

Requirements Related to Surprise Billing; Part I ([TRP analysis](https://myemail.constantcontact.com/CMS-Releases-Second-Interim-Final-Rule-on-Surprise-Billing.html?soid=1130896595582&aid=M_zTqncl6qs); [rule](https://public-inspection.federalregister.gov/2021-21441.pdf); [press release](https://www.cms.gov/newsroom/press-releases/biden-harris-administration-advances-key-protections-against-surprise-medical-bills-giving-peace); [fact sheet](https://www.cms.gov/newsroom/fact-sheets/requirements-related-surprise-billing-part-ii-interim-final-rule-comment-period))

* This interim final rule (IFR) addresses an independent dispute resolution (IDR) to determine out-of-network rates for **emergency services** (out-of-network facility and/or out-of-network provider) and **nonemergency services furnished by nonparticipating providers at participating facilities**.
* The IDR process allows plans and insurers to determine OON rates for emergency services after an unsuccessful open negotiation. The rule also discusses good faith estimates of health care items and services for uninsured or self-pay individuals and the associated patient-provider dispute resolution process. Additionally, the rule contains OPM clarifications regarding the No Surprises Act provisions that apply to health benefits plans offered by carriers under the Federal Employees Health Benefits (FEHB) Act.
* The IFR requires that providers and facilities inquire about the health insurance status or potential claim status of an individual when scheduling an item or service for, or if requested by, that individual. Providers and facilities are required to issue a good faith estimate of anticipated charges for services to an individual who is either uninsured or considered self-pay. Specifically, individuals who qualify under these two categories either: (1) do not have benefits covering an item or service under specified health plans or (2) have such benefits under specified health plans, but do not seek to have a claim submitted to their plan, issuer, or carrier for the item or service. The IFR provides guidance as to what a good faith estimate entails and specifies that all expected charges for items or services that are provided in conjunction with a primary item or service must be included in the estimate.
* The rule also establishes a patient-provider dispute resolution process to determine a payment amount in the event that an uninsured or self-pay individual receives a good faith estimate and is subsequently billed for an amount substantially in excess of said estimate. The rule provides eligibility details for this dispute resolution process, a definition of “substantially in excess,” and further information on the selection process for selected dispute resolution (SDR) entities that will oversee dispute resolution.

Prescription Drug and Health Care Spending ([TRP analysis](https://myemail.constantcontact.com/Biden-Administration-Issues-New-Prescription-Drug-and-Health-Care-Spending-Reporting-Requirements.html?soid=1130896595582&aid=m4lzbknMXvY); [rule](https://public-inspection.federalregister.gov/2021-25183.pdf); [press release](https://www.hhs.gov/about/news/2021/11/17/biden-harris-administration-improves-transparency-and-oversight-of-prescription-drug-and-medical-costs.html); [fact sheet](https://www.cms.gov/newsroom/fact-sheets/prescription-drug-and-health-care-spending-interim-final-rule-request-comments))

* This interim final rule with comment (IFC) requires health plans and health insurance issuers in the group and individual markets to submit certain information on prescription drug costs and other health care spending to the Departments of Health and Human Services (HHS), Labor, and Treasury each year.
* Specifically, submissions must include: (1) plan and coverage information; (2) impacts of prescription drug rebates, fees, and other remuneration on premiums and out-of-pocket costs; (3) enrollment and premium information; (4) total health care spending categorized by type and cost; and (5) rebates, fees, and other remuneration paid by drug manufacturers for specified drugs.