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CLIENT ALERT

The No Surprises Act: Implications for Health Plans, Health Care Facilities, and Health Care Providers

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Following months of congressional negotiations, on December 27, 2020, President Trump signed into law the Consolidated Appropriations Act, 2021, a $2.3 trillion piece of legislation that includes $900 billion in federal funding and relief for COVID-19.[1] The legislation also includes the No Surprises Act ("Act"), effective January 1, 2022, which significantly bolsters consumer protections for patients by addressing the circumstance of patients receiving "surprise bills" for health care services.[2] While we expect the Biden administration to issue regulations implementing the Act within the next year, stakeholders should be aware of the Act's many new obligations on health plans,[3] health care facilities, and health care providers.

This Client Alert summarizes the Act's (1) surprise billing and balance billing prohibitions, (2) the negotiation and independent dispute resolution ("IDR") process for rate disputes between health plans and out-of-network health care facilities and providers, and (3) health care industry notice and disclosure requirements.

1. Surprise Billing and Balance Billing Prohibitions

The Act increases patient protections from surprise bills. It requires that health plans and out-of-network health care providers hold enrollees harmless and prohibits out-of-network (i.e., non-participating) providers from billing enrollees above in-network amounts for emergency services and non-emergency services in certain situations.

[1] Public Law No. 116-260 (Dec. 27, 2020).
[2] Consolidated Appropriations Act, 2021, Division BB, Title I.
[3] The Act applies to individuals covered by group health insurance coverage and individual health insurance coverage. In this Client Alert, we use the term "health plan" to refer to (1) any group health plan or health insurance issuer offering group or individual health insurance coverage under the Public Health Service Act, (2) any group health plan or health insurance issuer offering group health insurance coverage under the Employee Retirement Income Security Act of 1974 ("ERISA"), and (3) group health plans under the Internal Revenue Code of 1986. We use the term "enrollee" to refer to any individual receiving coverage under a "health plan," as so defined.

Specifically, the Act impacts health plans, health care facilities, and health care providers in the following ways:

A. Health Plans. The Act requires that health plans hold harmless an enrollee for any amounts beyond in-network cost-sharing amounts charged by out-of-network emergency services providers, air ambulance services providers, and out-of-network providers providing covered services in in-network facilities in certain non-emergency situations when the enrollee does not have an adequate opportunity to select an in-network provider.[4] The Act further prohibits health plans from imposing limitations on coverage on patients receiving emergency services from out-of-network providers that are more restrictive than those limitations on coverage for in-network services.[5] Specifically, health plans must:

i. not impose a greater cost-sharing requirement than would be imposed if the emergency or non-emergency services were provided in-network;

ii. calculate the cost-sharing requirement as if the total amount that would have been charged was equal to the statutorily defined "Recognized Amount," set as:

a. the amount approved by the state in the case of items and services furnished in a state with an All-Payer Model Agreement; or

b. the market-based median in-network rate, called the "Qualifying Payment Amount,"[6] or

c. the amount determined in accordance with state law (to the extent the state has an applicable law); and

iii. count cost-sharing payments for such out-of-network emergency or non-emergency services toward any applicable in-network deductible or out-of-pocket maximum.

B. Health Care Facilities and Providers

i. *Out-of-Network Facilities and Out-of-Network Providers of Emergency Services.* The Act prohibits out-of-network facilities and out-of-network providers of emergency services from billing insured patients or

[4] No Surprises Act § 102.
[5] *Id.*
[6] *Id.* While "Qualifying Payment Amount" has a complex statutory definition, it generally means (1) for an item or service furnished during 2022, the median of the contracted rates recognized by the health plan on January 31, 2019, for the same or a similar item or service that is provided by a similar provider in the same geographic region, increased by the percentage increase in the Consumer Price Index for All Urban Consumers ("CPI-U") over 2019-2021, and (2) for an item or service furnished during 2023 or a subsequent year, the Qualifying Payment Amount for such an item or service furnished in the previous year, increased by the percentage increase in the CPI-U over such previous year.

holding insured patients liable for amounts beyond a cost-sharing requirement that may not be greater than the cost-sharing requirement that would apply if such emergency services were provided by an in-network facility or an in-network health care provider. The Act further provides that the maximum cost-sharing requirement is based upon the "Recognized Amount."[7]

ii. *Out-of-Network Providers of Air Ambulance Services.* As with non-participating facilities and non-participating providers of emergency services, the Act prohibits out-of-network providers of air ambulance services from billing insured patients or holding insured patients liable for amounts beyond a cost-sharing requirement, which must be the same cost-sharing requirement that would apply if such services were provided by an in-network provider.[8]

iii. *Out-of-Network Providers of Non-Emergency Services at In-Network Facilities.* For non-emergency services provided by an out-of-network provider during a visit at an in-network facility, the Act requires the non-emergency services provider to hold an enrollee harmless for amounts beyond the in-network cost-sharing requirement unless the out-of-network provider gives the enrollee notice and obtains the enrollee's prior consent.[9]

To satisfy the notice and consent exception for out-of-network providers of non-emergency services to bill enrollees an amount greater than the in-network cost-sharing amount (an exception that applies only to this category of out-of-network non-emergency services at in-network facilities), the out-of-network provider must give the enrollee (1) written or electronic notice of the provider's out-of-network status, (2) a list of in-network providers that the enrollee could see instead, and (3) a good faith estimate of the enrollees charges at least 72 hours prior to furnishing the out-of-network services.[10] The enrollee must sign a consent to receive the services from the out-of-network provider and acknowledge that he or she received the written or electronic notice.[11]

The Act specifically excludes from the notice and consent exception all ancillary services or items or services furnished as a result of unforeseen, urgent medical needs that arise after the patient consented to the out-of-network non-emergency care at an in-network facility, which are always subject to the surprise and balance billing prohibitions applicable to emergency services provided by out-of-

[7] *Id.* § 104(a).
[8] *Id.* § 105.
[9] *Id.* § 104(a).
[10] *Id.*
[11] *Id.*

network health care providers.[12] Furthermore, the notice and consent exception does not apply to any items and services provided by an out-of-network provider when there was no alternative in-network provider at the facility who could furnish the covered item or service. The Act considers such services to be "ancillary services."[13] Other services considered to be "ancillary services," and thus always subject to the billing prohibitions by out-of-network providers of amounts beyond the in-network cost-sharing requirement, include:[14]

a. services related to emergency medicine, anesthesiology, pathology, radiology, and neonatology (whether or not provided by a physician or non-physician practitioner);

b. items and services provided by assistant surgeons, hospitalists, and intensivists;

c. diagnostic services, including radiology and laboratory services;[15] and

d. items and services provided by certain specialty practitioners (which will be specified through future rulemaking).

2. Negotiation and Independent Dispute Resolution Process

The Act provides for a negotiation and IDR process when health plans and out-of-network health care facilities or providers disagree about charges for emergency services, air ambulance services, and non-emergency services provided by out-of-network providers at in-network facilities. While the Act states that the U.S. Department of Health and Human Services ("HHS"), jointly with the U.S. Department of Labor ("DOL") and the U.S. Department of the Treasury ("Treasury"), will issue regulations setting forth the specific IDR process by December 27, 2021, the Act sets forth the following parameters for the IDR process:

A. The Timely "Initial Payment" or Notice of Denial from the Health Plan. A health plan has 30 calendar days after the out-of-network health care facility or provider sends the bill to make an "initial payment" or send a notice of denial of payment.[16] Significantly, the Act does not define what amount should be paid by the health plan as the "initial payment."

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[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.* The Act anticipates that HHS will establish a list of advanced diagnostic laboratory tests that will be excluded from the Act's enrollee's billing protections for ancillary services.
[16] *Id.* §§ 102, 105. "[T]he group health plan or health insurance issuer, respectively—(I) not later than 30 calendar days after the bill for such services is transmitted by such provider or facility, sends to the provider or facility, as applicable, an initial payment or notice of denial of payment. . . ."

B. The Timely Triggering of the Open Negotiation Period by Either Party and the Open Negotiation Period. Beginning the day the out-of-network facility or provider receives the health plan's response to the bill (i.e., the initial payment or the notice of denial), either the health plan or the out-of-network facility or out-of-network provider has a "30-day period" to initiate an open negotiation period to negotiate an agreed amount—including any cost sharing—for the out-of-network item or service.[17] The open negotiation period starts on the day of initiation and lasts for 30 days.

C. The IDR Process. If the out-of-network facility or out-of-network provider and health plan fail to agree on the payment amount during the 30-day open negotiation period, any party may initiate the IDR process before an independent, unbiased certified IDR entity.[18]

i. *Prompt Initiation*. Either party may initiate the IDR process by submitting a notification of initiation (the parameters of which will be determined by regulation) to the other party and HHS within a four-day period beginning the day after the end of the open negotiation period.[19]

a. Batching of Claims. There is no minimum payment threshold required for a party to pursue the IDR process. If certain criteria are met, the IDR entity may bundle for consideration items or services furnished by the same out-of-network health care facility or out-of-network provider that require payment from the same health plan and are related to the same treatment or a similar condition that were furnished within 30 days of the first item or service at issue.[20]

ii. *Selection of IDR Entity*. Within three business days following the date of initiation, the parties must jointly select an IDR entity. If the parties do not make a joint selection, within "6 business days" of the date of initiation, HHS must select an IDR entity and provide notice of the IDR entity to the parties.[21]

iii. *Submission of Offers*. Not later than 10 days after the selection of the IDR entity, the parties must submit to the IDR entity an offer for a payment amount for the item or service at issue, as well as any information requested by the IDR entity.[22] The parties may also

[17] *Id.* §§ 103, 105.
[18] *Id.* The Act provides that HHS, in consultation with the DOL and the Treasury, will establish a process to certify and select IDR entities. With respect to non-emergency services provided by out-of-network providers at in-network facilities, the IDR process would not be available where the out-of-network provider meets the notice and consent requirements.
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*

submit any other information relating to the offer it submits. See below for possible information a party may want to submit to assist the IDR in its responsibilities.

iv. *Payment Determination Considerations*. The IDR entity will select which offer is the payment to be applied for the items or services at issue no later than "30 days after the selection" of the IDR entity. In making such a determination, which is binding and not subject to judicial review, the Act provides that the IDR entity must consider certain factors and is prohibited from considering other factors.

a. Mandatory Considerations. In making a payment determination, the IDR entity ***must*** consider:[23]

1. the "Qualifying Payment Amount" for the item or service at issue, which generally is the market-based median in-network rate;

2. the level of training, experience, and quality and outcomes measurement of the out-of-network provider or out-of-network facility;

3. the market share held by the out-of-network provider, out-of-network facility, or health plan in the geographic region;

4. the acuity of the individual (patient) receiving the covered item or service or the complexity of furnishing the item or service to that individual;

5. the teaching status, case mix, and scope of services of the out-of-network facility;

6. demonstrations of good faith efforts (or a lack of good faith efforts) from the out-of-network provider, out-of-network facility, or health plan to enter into a network agreement;

7. if applicable, contracted rates during the previous four plan years;

8. other information requested by the IDR entity; and

9. any other information submitted by the party relating to that party's offer.

[23] *Id.*

b. Prohibited Considerations. The IDR entity ***is prohibited*** from considering:[24]

1. usual and customary charges;

2. the amount that would have been billed if the surprise and balance billing protections in the Act had not applied; and

3. the payment or reimbursement rate a public payor, including Medicare, Medicaid, CHIP, and TRICARE, would have paid for the covered items or services at issue.

v. *Payment*. The health plan must pay the out-of-network facility or out-of-network provider "not later than 30 days after" the IDR entity's determination.[25] For 90 days following the IDR's determination, the party that initiated the IDR process may not submit a subsequent notification to enter IDR for the same covered item or service that was the subject of the initial IDR process.[26]

D. Costs. The Act provides that, if the IDR entity makes a payment determination, the party whose offer is not chosen is responsible for paying all of the fees charged by the IDR entity for performing the IDR process for the parties. If the parties reach a settlement prior to a payment determination by the IDR entity, the parties split the fees charged by the IDR entity.[27]

3. Notice and Disclosure Requirements

The Act imposes a number of notice and disclosure provisions to help ensure that enrollees are aware of the billing prohibitions and protections afforded to them in the Act.

A. Health Plans

i. *Disclosures of Balance Billing Protections*. Health plans and issuers must make available a notice on their website that contains language disclosing the Act's prohibitions against billing in amounts beyond the in-network cost-sharing amounts in the relevant categories, and what state or federal agencies to contact if an

[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

individual believes that a health care provider or facility has violated a billing prohibition in the Act.[28]

ii. *Updated Insurance Cards*. Health plans must provide insurance cards that disclose any applicable deductible or out-of-pocket maximum limitation as well as a telephone number and internet address for consumer questions.[29]

iii. *Advanced EOBs*. Health plans must provide enrollees with an "Advanced Explanation of Benefits" for scheduled services with information including the facility's or provider's network status and good faith estimates of charges and health plan and enrollee cost-sharing amounts.[30]

iv. *Notification of Network Status Changes for Continuing Care Patients*. Health plans and issuers must notify continuing care patients of changes in network status of treating providers, provide the continuing care patient with an opportunity to notify the health plan or issuer of the need for transitional care, and permit the patient to elect to continue to have benefits provided under the same terms and conditions as would have applied had the termination not occurred for a period ending on the earlier of 90 days or until the patient is no longer a continuing care patient.[31]

v. *Price Comparison Tool*. Health plans must maintain a price comparison tool for enrollees to compare the amount of cost sharing that the individual would be responsible for paying with respect to the furnishing of a specific item or service by any participating provider.[32]

vi. *Updated Provider Directories*. Health plans must maintain up-to-date network provider directories and verify provider directory information to remove providers who are no longer in-network and to respond to enrollees who inquire about the network status of providers.[33] If an enrollee provides documentation that he or she received incorrect information from the health plan regarding a provider's network status, the enrollee will only be responsible for the in-network cost-sharing amount.

[28] *Id.* §§ 116(a-c).
[29] *Id.* § 107.
[30] *Id.* §§ 111(a-c).
[31] *Id.* § 113(a-c).
[32] *Id.* § 114.
[33] *Id.* § 116.

B. Health Care Facilities and Providers

i. *Disclosures of Patient Protections Against Balance Billing.* Health care facilities and providers must make publicly available, post on their website, and provide to insured patients a one-page notice that contains the requirements relating to (1) the Act's prohibitions on billing in amounts beyond the in-network cost-sharing amounts in the relevant categories, (2) other applicable state law requirements relating to such billing prohibitions, and (3) information on which state or federal agencies to contact if an individual believes a health care facility or provider has violated a federal or state billing prohibition.[34]

ii. *Notice of Good Faith Estimates for Scheduled Services*. Health care facilities and providers, both in- and out-of-network, must notify patients and health plans of their good faith estimates of expected charges for scheduled covered services based on the expected billing and diagnostic codes.[35] The Act also states that HHS must establish, by January 1, 2022, a patient-provider dispute resolution process for uninsured individuals who receive bills substantially in excess of good faith estimates of expected charges from any health care facilities or providers.[36]

iii. *Notice of Facility and Provider Network Status.* Health care facilities and providers must establish a process to notify health plans and issuers of network status changes and provider directory information.[37] If an incorrect network status is provided to an enrollee and the enrollee pays an amount in excess of the in-network cost-sharing amount, the provider must refund the excess amount, plus interest.[38]

Conclusion

It is clear from the Act that certain key terms and processes will need to be further defined through the federal rulemaking process, which is expected later this year. We note, as one small but critical example, that the Act imposes certain timeframes by reference to "days," some of which are identified as "calendar" or "business" days, whereas others are used generically. It is likely that these regulations will be issued by the same federal entities that administer and oversee regulation of the individual, small, and large group markets under the Affordable Care Act, including the Internal Revenue Service within the Treasury, the Employee Benefits Security Administration within the DOL, and the Center for Consumer Information and Insurance Oversight within the

[34] *Id.* § 104(a).
[35] *Id.* § 112.
[36] *Id.*
[37] *Id.* § 116(e).
[38] *Id.*

Centers for Medicare & Medicaid Services at HHS. We urge all interested parties to comment on such regulations to help these federal agencies provide the health care industry with as much clarity as possible regarding what constitutes compliance with this Act.

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