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More Surprises on Surprise Billing: Will Federal or State Law Control?

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In this article, the authors provide an overview of the concurrent federal and state jurisdiction Congress created through the No Surprises Act and discuss key issues that stakeholders should consider now that the Biden administration has released regulations implementing the law.

When introducing the No Surprises Act ("NSA") – signed into law on December 27, 2020, as part of the Consolidated Appropriations Act, 2021 – leaders of the responsible committees of the U.S. House of Representatives announced that they had "reached a bipartisan, bicameral deal in principle to protect patients from surprise medical bills and promote fairness in payment disputes between insurers and providers, without increasing premiums for patients or *interfering with strong, state-level solutions already on the books*."[1] In other words, Congressional intent was that federal surprise billing protections would not preempt already enacted state-level surprise billing protections. While the U.S. Office of Personal Management and the Departments of Health and Human Services, Labor, and the Treasury (the "Departments") issued an interim final rule with a request for comment (the "First NSA Rule")[2] on July 13, 2021, that in part attempted to clarify the interaction between

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state laws and the NSA, the question of whether federal or state law controls remains complex given the wide variation in states' legislative efforts to address surprise billing and the evolving list of variables stakeholders must consider when implementing the NSA.[3]

This article provides an overview of the concurrent jurisdiction Congress created through the NSA and discusses key issues stakeholders should consider as the Departments continue to release regulations in preparation for the NSA's January 1, 2022, effective date.

STATE-LEVEL SURPRISE BILLING LAWS

Congress enacted the NSA to protect consumers against "surprise billing" – balance billing a patient under commercial coverage above their in-network amount for covered emergency services provided by an out-of-network ("OON") provider or facility or for certain covered nonemergency services provided by an OON provider at an in-network facility. We refer to these herein as "NSA-covered services."

According to the Commonwealth Fund, 18 states have implemented broad-based surprise billing laws and 15 other states have laws that address certain issues related to surprise billing.[4] These state laws differ significantly in a variety of ways, including according to:

(1) Which types of plans or issuers, items, services, and specialties the laws apply;

(2) How the laws determine the applicable OON payment amounts; and

(3) The methodology used to resolve payment disputes.

Similar to the NSA, states with broad-reaching surprise billing laws often define a process to determine the payment amount owed by both the plan and the patient to the OON provider or facility. The process used to determine the payment amount, however, varies by state, with approaches including, but not limited to, benchmarking, negotiation, and independent dispute resolution ("IDR").

Some state surprise billing laws include a "notice-and-consent exception," also adopted in the NSA, which permits an OON provider to bill a covered patient above the patient's in-network cost-sharing amount if the OON provider meets certain notice and disclosure requirements and the patient provides requisite consent. Requirements and applicability of the notice-and-consent exceptions similarly vary by state.

CONCURRENT JURISDICTION UNDER THE NSA, CARVE-OUTS FOR THE PAYMENT AND COST-SHARING DETERMINATIONS & THE IMPLICATIONS FOR OTHER STATE LAW PROVISIONS

Under the Supremacy Clause of the U.S. Constitution, state laws that conflict with a federal law are generally preempted. However, while components of the NSA and certain state legislation overlap, the NSA expressly defers to state surprise billing laws in two key areas: (1) state provisions addressing the amount an insurer must pay an OON provider or facility for NSA-covered services,[5] i.e., the "Out-of-Network Rate," which includes however the state solves payment disputes, and (2) provisions on calculating the "Recognized Amount," which is used to determine the applicable cost-sharing amount.[6]

Determination of the Out-of-Network Rate

The NSA requires plans to pay the OON provider or facility for NSA-covered services at the Out-of-Network Rate, less the applicable cost-sharing amount for the services.[7] If the state with jurisdiction over the provider, facility, and plan does not have an applicable All-Payer Model Agreement[8] – an all-payer rate-setting system implemented pursuant to Section 1115A of the Social Security Act – and the state does not have an applicable Specified State Law, the Out-of-Network Rate will be the agreed-upon or IDR-specified amount as determined under the NSA. For a state-level surprise billing law to be considered a "Specified State Law," the state law must:

1. Apply to the plan;
2. Apply to the OON provider or OON emergency facility;
3. Apply to the OON items and/or services; and
4. Include a method for determining the total OON payment amount.[9]

Determination of the Recognized Amount for Cost Sharing

Where the NSA applies, plans, providers and facilities are generally prohibited from imposing a cost-sharing amount on an enrollee

greater than the cost-sharing requirement that would have applied if the service had been provided in-network.[10] The cost-sharing amount – which includes copayments, coinsurance, and deductibles – must be calculated based upon the "Recognized Amount." Similar to the process for determining the Out-of-Network Rate, the Recognized Amount will be the amount specified in the applicable All-Payer Model Agreement, and – if there is no All-Payer Model Agreement – then the applicable Specified State Law. If no Specified State Law applies, the Recognized Amount will be the lesser of the billed amount or the "Qualifying Payment Amount,"[11] – a market-based median-contracted rate detailed in the First NSA Rule.[12] As the NSA prohibits OON providers and facilities from billing enrollees for an amount greater than their in-network cost-sharing amount, plans must provide the OON provider or facility with the Qualifying Payment Amount for each OON item and/or service in issuing its initial payment or denial.

Other Components of State Law Impacted by the NSA

While the NSA expressly addresses the role of state laws for determining the Out-of-Network Rate and the Recognized Amount, the law does not clearly address the ongoing effect of other aspects of state-level surprise billing laws. Applying general principles of federalism, the First NSA Rule attempted to address this ambiguity, confirming that the NSA "seek[s] to supplement, rather than supplant state balance billing laws."[13] As a result, state laws consistent with or providing protections beyond the statutory framework of the NSA are not preempted and may continue in effect concurrently with the balance billing protections set forth in the NSA to the extent such state laws do not conflict with the NSA. The NSA preempts state law provisions less restrictive than the NSA.

Stakeholders must be aware that state laws affect implementation of several provisions of the NSA. The First NSA Rule clarified that in addition to meeting the disclosure requirements applicable to the provider or facility under the NSA, providers and facilities must also include any disclosure information required under state law. Additionally, the NSA enumerates compliance with applicable state laws as one of the criteria required to permit an OON provider or facility to balance bill an enrollee for certain post-stabilization services. State-level licensing laws may also affect whether an urgent care center is subject to the NSA's emergency balance billing prohibitions.

IMPLICATIONS AND FURTHER QUESTIONS

The NSA's concurrent jurisdiction framework will interact differently with each state's surprise billing laws due to the significant variation in states' approaches to surprise billing and the lack of alignment in policy approach under state laws and the NSA. As a result, a preemption analysis must be completed for each state to determine (1) whether there is an applicable Specified State Law for determining the Out of Network Rate and Recognized Amount and (2) if other aspects of the states' surprise billing laws are more protective than and, therefore, control over related provisions of the NSA.

Assuming a state's surprise billing law applies to the type of provider or facility and the type of NSA covered services at issue, the affected patient's plan is material to determine whether state or federal law controls as part of the Specified State Law analysis. For enrollees in fully-insured plans who receive NSA covered services in any such state, the state's balanced billing law will generally apply to determine the Out-of-Network Rate for the NSA-covered services. For enrollees in self-insured plans who receive NSA covered services in the same state, the NSA would generally control to determine the Out-of-Network Rate for NSA-covered services received by the enrollee.[14] For enrollees in either fully or self-insured plans who receive NSA-covered services in states without state-level surprise billing laws, the NSA will always apply to determine the Out-of-Network Rate for such services.[15]

To add yet another level of complexity, some states' surprise billing laws defer to federal law for payment methodologies for certain services, as state legislators anticipated the enactment of a federal law on surprise billing, like the State of Washington's surprise billing provisions regarding OON emergency services. Additionally, several states have provisions allowing ERISA-regulated plans to "opt-in" to state-level surprise billing laws. The Departments explicitly confirmed that deference to state law included deference to state opt-in provisions as this was "consistent with the overarching structure" of the NSA. This could spur legislative activity if additional states attempt to adopt such provisions. Notably, in the First NSA Rule, the Departments also requested comments on possibly permitting plans, providers, and facilities to opt-in for certain items or services on an episodic basis. As the Departments acknowledge, such a policy could increase prices if providers and patients selectively game the system. Such a policy would also increase the administrative burdens for stakeholders attempting to implement and comply with the NSA.

Stakeholders must be aware that even episodes of care may require individual analyses. For example, the Specified State Law analysis

could lead to both the NSA and a Specified State Law applying to certain items and services from the same episode of care, depending on whether all items and services satisfy the "Specified State Law" criteria. The analysis of additional variables – such as notice-and-consent exceptions and the scope of visits and facilities that trigger surprise billing protections – may be material, which demonstrates the challenges from the lack of alignment between state laws and the NSA. For example, Texas' laboratory provider surprise billing law applies more broadly than the NSA as it is not limited to services performed within a visit for nonemergency services at "facilities" – defined by the NSA to include hospitals, critical access hospitals, outpatient departments, and ambulatory surgical centers. However, Texas' laboratory provider surprise billing law permits OON laboratory providers to balance bill for OON laboratory services upon satisfaction of Texas' notice-and-consent exception, while the NSA does not permit providers of ancillary services, such as laboratory services, to use the NSA's notice-and-consent exception.[15] As a result, OON laboratory providers in Texas may be prohibited from balance billing for processing a particular test on a specimen taken as part of a visit at a facility under the NSA while being permitted to balance bill using Texas' notice and consent exception if the specimen was collected during a service provided at a facility not subject to the NSA protections.

FAST-PACED CHANGES AHEAD

Although the Departments issued the First NSA Rules this past July, the NSA imposes additional near-term regulatory deadlines covering various aspects of the NSA, including establishing the IDR process (due by December 27, 2021) and a patient-provider dispute resolution process (due by January 1, 2022). The Departments further noted in the preamble to the First NSA Rule that their rulemaking for some of the NSA provisions may occur after the NSA's January 1, 2022, effective date. For those provisions, the Departments expect plans and issuers to "implement the requirements using a good faith, reasonable interpretation of the statute," and plan to issue further guidance regarding those expectations.[16]

With the impending NSA effective date quickly approaching, stakeholders must act even in the absence of federal implementing regulations or guidance, while continuing to monitor for insight from regulators. Further, in addition to expecting significant activity on the federal level, stakeholders should also anticipate notable activity on the state-level as states react to implementation of the law. Implementation will be an ongoing effort that – without

question – will have a sweeping and significant impact on providers, facilities, and health plans.

NOTES

1. Press Release, Committee Leaders Announce Surprise Billing Agreement (Dec. 11, 2020), *available at https://www.help.senate.gov/chair/newsroom/press/congressional-committee-leaders-announce-surprise-billing-agreement*(emphasis added).

2. Requirements Related to Surprise Billing; Part I, 86 Fed. Reg. 36872 (July 13, 2021), *https://www.federalregister.gov/documents/2021/07/13/2021-14379/requirements-related-to-surprise-billing-part-i*.

3. This article uses the term "health plan(s)" or "plan(s)" 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 "in-network" to cover the terms "participating," "contracted," and similar terms, while we use the term "out-of-network" to cover the terms "nonparticipating," "non-contracted," and other similar terms.

4. *See* Commonwealth Fund, State Balance-Billing Protects (Feb. 5, 2021), *available at https://www.commonwealthfund.org/publications/maps-and-interactives/2021/feb/state-balance-billing-protections*.

5. *See* 29 U.S.C. § 1185e (ERISA), 26 U.S.C. § 9816 (Internal Revenue Code), and 42 U.S.C. § 300gg-111 (Public Health Service Act).

6. *Id*.

7. *Id*.

8. The NSA defers to the state for the Out-of-Network Rate where the state has an All-Payer Model Agreement or an applicable surprise billing law. At present, only three states have All-Payer Model Agreements: Maryland, Pennsylvania, and Vermont.

9. 86 Fed. Reg. at 36885.

10. *See* 29 U.S.C. § 1185e (ERISA), 26 U.S.C. § 9816 (Internal Revenue Code), and 42 U.S.C. § 300gg-111 (Public Health Service Act).

11. *Id.*

12. *Id.*

13. 86 Fed. Reg. at 36886, 36931.

14. *See* 42 U.S.C. § 300gg-132 ("[the prohibition on surprise billing] shall not apply with respect to items or services (other than ancillary services . . . if the provider satisfies the notice and consent criteria").

15. *Id*.

16. *Id*. at 36876.