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The No Surprises Act: A Final Checklist for 2022

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The No Surprises Act ("NSA") passed in the final days of 2020 as part of the Consolidated Appropriates Act, 2021 to create a federal solution to the problem of "surprise billing." Most provisions of the NSA took effect on January 1, 2022. In this article, we provide a final "checklist" for providers and facilities to take inventory of their NSA compliance and operational measures as we dive into the new year.

- No Surprises Act Disclosures. Certain providersii and facilitiesiv must notify patients of their rights under the NSA on a public website, and by providing to patients in a one-page written document, disclosures that include: (1) the requirements and prohibitions applicable to the provider or facility under the NSA and its implementing regulations; (2) information regarding any state balance billing laws;v and (3) information about how to contact state and federal agencies if the patient believes the provider or facility has violated the NSA.[vi]

- Implement the Notice and Consent Process. The NSA does not apply to some out-of-network services when the patient is given notice and consents to the out of network care. Providers should develop systems to identify those encounters eligible for the notice and consent process and implement a procedure for giving notice and obtaining consent. [vii]

- Prepare to Engage in the Independent Dispute Resolution ("IDR") Process for Reimbursement Disputes. Health plans and issuers must reimburse providers and facilities directly for out-of-network services subject to the NSA at an undefined amount the NSA calls the "initial payment." This "initial payment" must be made within 30 days after claim submission. The provider or facility may accept that amount as payment in full or dispute the amount through a statutory IDR process. The IDR process begins within a 30-day open negotiation period.viii The open negotiation period is followed by submission of the dispute to a third-party arbiter when the parties cannot settle.ix If the dispute is submitted to an arbiter, the parties must submit a final offer and the arbiter must select one of the two offers submitted as the prevailing award.

- Understand What Factors Are Considered at the IDR Process. When a dispute involves providers (excluding air ambulance providers)x or facilities, the arbiter of the IDR process must consider seven general factors in reimbursement disputes involving providers and

facilities: (1) median innetwork rates (as calculated by the plan or issuer); (2) the provider's training and experience, quality, and outcomes; (3) the market share of either party; (4) patient acuity or complexity of the service; (5) in the case of a hospital, its teaching status, case mix, and scope of services; (6) good faith efforts (or lack thereof) of either party to agree to a network contract and any contracted rates during the prior four years; and (7) any additional information submitted, so long as it is credible and reliable and does not relate to the provider's billed charges, UCR charges, or governmental reimbursement rates.

- Understand the Burden of Proof at the IDR Process. The Departmentsxi imposed a mandatory presumption through regulation that the health plan or issuer's median contracted rate is the appropriate reimbursement rate. This presumption may be rebutted only by "credible" and "relevant" information that the median contracted rate is "materially different" than the appropriate rate.

- Implement Good Faith Estimates for Uninsured (or Self-Pay) Patients. At the time of scheduling or upon request, providers and facilities must inquire about the patient's health insurance status or whether the patient wants to submit a claim to their health plan or issuer for the care sought. If the patient is uninsured (or self-pay), the provider or facility must give a good faith estimate of expected charges for services reasonably expected to be provided, including services that may be furnished by other providers or facilities.[xii]

- Prepare to Engage in Reimbursement Disputes for Uninsured (or Self-Pay) Patients. An uninsured or self-pay patient may institute a patient-provider dispute resolution process when the provider's final bill is $400 or greater than the original good faith estimate (discussed above). In this dispute process, the provider or facility must demonstrate that the difference between the amount billed and the good faith estimate is based on unforeseen circumstances not anticipated when the estimate was provided.

- Take Note of Uncertainty in Washington Over Existing NSA Rules. Industry associations and lawmakers have publicly denounced the presumption that the health plan or issuer's median contracted rate should be presumed an appropriate level of reimbursement via lettersxiii to the Departments and lawsuits [xiv] against the federal government. It is unclear whether regulators will amend the regulations in response, but this uncertainty is worth the industry's continued attention.

Footnotes

[i]Surprise billing sometimes occurs when patients unintentionally receive emergency or non-emergency services from providers who do not participate in their health plan's network. Patients often bear the financial burden of such out-of-network care. While some states have enacted laws addressing this issue in varying ways to protect patients from surprise bills, not all states have, and even those states with existing law on the books are generally unable to regulate many patient encounters, including those encounters with patients who have health coverage under self-funded health benefits plans regulated by the federal Employee Retirement Income Security Act of 1974 ("ERISA"). The NSA addresses this problem on a federal level to "fill the gaps" where states have not enacted (or are unable to enact) laws regulating encounters with patients who have commercial health coverage. We summarized many of the NSA's key features in our Reimbursement and Payor Dispute Update published in February, 2021. But generally speaking, the NSA does four major things: (1) prohibits balance billing and limits a patient's financial responsibility for certain out-of-

network care to the amount for which the patient would be responsible had those services been furnished by in-network providers; (2) requires health plans and issuers to reimburse providers directly for such out-of-network care and resolve reimbursement disputes under a statutory independent dispute resolution ("IDR") process; (3) creates protections for uninsured and self-pay patients and a patient-provider dispute resolution process; and (4) imposes additional transparency requirements. Congress delegated many important aspects of the NSA to federal agencies in rulemaking that occurred throughout 2021.

[ii] This checklist is intended to be a high-level summary of the NSA's requirements and does not account for all nuances in the law. For more information and questions related to the NSA or its implementing regulations, please contact the authors.

[iii] Excluding air ambulance providers.

[iv] Including hospitals and independent free-standing emergency departments.

[v] The NSA defers to existing state surprise billing laws in certain situations. Any comprehensive state surprise billing law will likely apply instead of the NSA in the context of a fully-insured plan and state-regulated insurance product (and sometimes self-funded ERISA plans if the particular state allows such plans to "opt-in" to state law) if the state law meets the NSA's so-called "floor requirements" by: (1) prohibiting balance billing like the NSA; (2) limiting patient cost-sharing to INN amounts; and (3) setting forth either a process to resolve disputes over OON reimbursement, like arbitration, or a mathematical formula for determining the total OON reimbursement rate for the item or service in question.

[vi] CMS has released a model disclosure that, if used by providers and facilities, will be deemed as good faith compliance with the NSA's disclosure requirements.

[vii] CMS has released form notice and consent documents that must be used. viii CMS has released a form "Open Negotiation Notice" that must be used to initiate this process.

[ix] CMS has released a form "Notice of IDR Initiation" that must be provided to the opposing party and to CMS using the new Federal IDR portal.

[x] The factors considered at the IDR process involving an air ambulance provider are slightly different: (1) median contracted rates; (2) the air ambulance providers' training and experience, quality, and outcomes; (3) patient acuity and complexity of service; (4) air ambulance vehicle type, including the vehicle's clinical capabilities; (5) population density of the pick-up location; (6) good faith efforts (or lack thereof) of either party to agree to a network contract, and any contracted rates during the prior four years; and (7) any additional information submitted, so long as it is credible and reliable and does not relate to the provider's billed charges, UCR charges, or governmental reimbursement rates.

[xi] The NSA made parallel amendments to provisions of the Public Health Service ("PHS") Act, which is enforced by the Department of Health and Human Services ("HHS"); ERISA, which is enforced by the Department of Labor; and the Internal Revenue Code ("IRC"), which is enforced by the Department of the Treasury. Congress delegated rulemaking to these Departments, along with the Office of Personnel Management ("OPM") (which oversees health benefits plans offered by carriers under the Federal Employees Health Benefits Act). These Departments have issued two primary sets of interim final rules in 2021 implementing portions of the NSA: Requirements Related to Surprise Billing; Part I ("Part 1 IFR"), and Requirements Related to Surprise Billing; Part II ("Part 2 IFR"),

which were published in the Federal Register on July 13, 2021, and October 7, 2021, respectively. We summarized key takeaways of the Part 1 IFR in our Reimbursement and Payor Dispute Update published in October, 2021.

[xii] CMS has released model good faith estimate documents that, if used by providers and facilities, will be deemed as good faith compliance with the NSA's good faith estimate requirements for uninsured (or self-pay) patients. The NSA has a parallel good faith estimate requirement for patients with commercial health plans / insurance, but that requirement has been delayed. See FAQs About Affordable Care Act and Consolidated Appropriations Act, 2021, Implementation Part 49 (Aug. 20, 2021).

[xiii] On October 4, 2021, the House Committee on Ways and Means wrote a bipartisan letter to the Departments voicing in no uncertain terms that the presumption in favor of the median contracted rate contradicted Congressional intent. On November 5, 2021, nearly one-third of the House raised the same issue in a letter to the Departments signed by a bipartisan group of 152 lawmakers. Additionally, on December 6, 2021, Senator Mike Braun (R-IN) requested CMS and HHS reconsider the required presumption, arguing that this rule "creates a de-facto benchmark."

[xiv] On December 9, 2021, the American Health Association ("AMA"), American Hospital Association ("AHA"), and other industry players sued the federal government in the federal district court for the District of Columbia seeking declaratory and injunctive relief, alleging that the Departments acted outside of their statutory authority by issuing certain provisions of the IFRs. See American Hospital Association, AHA, AMA and others file lawsuit over No Surprises Act rule that jeopardizes access to care (Dec. 9, 2021), Specifically, the AMA and AHA assert that the IDR process, as written by the regulators, would unfairly benefit plans and insurers because of the IFRs' mandatory presumption that the median contracted rate is the appropriate rate to determine the final award. The AMA and AHA allege this requirement contradicts Congressional intent and express statutory language calling for the arbiter at the IDR process to consider all seven enumerated factors. Accordingly, the associations ask the Court to block the pertinent IFR provisions. A few weeks prior, the Texas Medical Association and Association of Air Medical Services filed similar lawsuits against the federal government in the district courts for East District of Texas and the District of Columbia, respectively. See Texas Medical Association, TMA Sues Feds Over Unfair Rule for Surprise Billing Law; AAMS, AAMS Sues Federal Government Over Rules Favoring Insurers.

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