Federal "No Surprises Act" Brings National Oversight of Unexpected Billing for Healthcare Services

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In the waning days of Donald Trump's administration, the federal government passed the "No Surprises Act," which becomes effective January 1, 2022. Like many recent state laws, the legislation is aimed at protecting patients from unexpected balances owed to healthcare providers outside of their network plans, particularly when there was no advance notice of the potential bills, as would often occur with respect to emergency services, or services from hospital-based providers when those providers are not in the patient's insurance plan network. The legislation seeks to remove patients from the middle of out-of-network reimbursement disputes.

Overview of Federal and NJ/NY State Laws

The reach of state laws addressing these issues has been limited, largely due to three reasons:

1. State laws relating to employee benefit plans that are not insured are preempted by the Federal Employee Retirement Income Security Act (ERISA);
2. Federal laws governing some government programs, such as Medicare Advantage and the Federal Employees Health Benefits Plan covering federal employees, also preempt many state insurance laws; and
3. State insurance laws are generally limited to insurance policies issued in that state, so a New York resident insured under an employer's Pennsylvania group policy may not fall under the protection of New York law.

Federal law can theoretically reach all of these circumstances however the No Surprises Act defers to state laws to the extent they apply to payment amounts. As such, the foreseeable future will be defined by a crazy quilt of state and federal requirements.

The No Surprises Act was included as part of the Consolidated Appropriations Act, 2021 that became effective on December 27, 2020 however most sections of the law do not go into effect until January 1, 2022. The Centers for Medicare & Medicaid Services (CMS) is charged with promulgating regulations, which are expected shortly.

New Jersey's Out-of-Network Consumer Protection, Transparency, Cost Containment, and Accountability Act became effective on August 30, 2018. Similar to New York State Public Health Law (PHL) §24, effective March 31, 2015, it requires healthcare payers and providers to make certain disclosures to patients and prospective patients regarding out-of-network providers and imposes limits on the ability of payers and providers to balance bill patients.

The federal law and many state laws, including those of New York and New Jersey, have the following basic tenets in common:

- Patients must be held harmless from unanticipated costs of medical treatment beyond the in-network cost-sharing responsibilities (deductibles, coinsurance and co-payments) under their health plans;
- Health plans and providers must make pricing and network status available; and

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- A dispute resolution process is established for payment disputes between plans and providers.

A threshold issue under all is whether the bill is a 'surprise' – unknowable in advance of receipt of services like emergency care or some other hospital-based services. Different rules apply to bills that should not be a surprise – those known and consented to in advance of the receipt of services including elective procedures.

The federal, New Jersey and New York laws track closely with what is considered to be a surprise, and in keeping patients out of the middle of balance billing disputes. The No Surprises Act anticipates regulations that will be much more prescriptive than either New Jersey or New York in terms of consents that would be required. It defers to existing state laws with respect to state-established payment amounts. For states like New Jersey and New York with rules for surprise medical billing disputes, the state's dispute resolution mechanism continues to govern disputes between insurers and out-of-network providers in that state for the fully insured plans they are able to regulate. The federal dispute resolution mechanism would reach those bills not subject to state law.

Major Provisions of the Federal Law & Summary Comparison to NJ/NY State Laws (Focus on Healthcare Providers Application)

Balance Billing

Under all three laws, balance billing as we know it will be prohibited for surprise bills. Patients unexpectedly receiving medical services from a provider out-of-network with the patient's health benefit plan will be required to pay no more than if the provider had been in-network with the patient's plan. Additional amounts sought must be worked out between the provider and payer, up to and including independent dispute resolution mechanisms as described below.

Transparency Regarding Non-Network Services

A. Federal Transparency Requirements

Cost transparency is an area where the No Surprises Law is significantly more prescriptive than the New Jersey and New York laws. The Health & Human Services (HHS) Secretary must issue further guidance on these requirements by July 1, 2021, including specifying the form to document patient consent.

Health plans are required to provide their members with an "advanced explanation of benefits" before an elective procedure, disclosing the provider's network status and a good faith estimate of the member's cost-sharing obligations. A good faith estimate of costs and cost-sharing by the health plan must identify whether the provider(s) furnishing the items or services is in-network and, if not, how to locate in-network providers. Insurers will also have to offer price comparison information by phone, develop a web-based price comparison tool, and maintain up-to-date provider directories.

Providers must make efforts to obtain the patient's enrollment status and provide "good faith estimates" of the total expected charges for scheduled items or services. This includes any expected ancillary services. The notice must also include the expected billing and diagnostic codes for all items and services to be provided. This requirement will apply whenever items or services are scheduled at least three days in advance or when requested by a patient. The provider will need to determine the patient's health coverage status and develop the "good faith estimate" at least three business days before the service is furnished and no later than one business day after scheduling, unless the service is scheduled for more than 10 business days later. In those instances, the provider will need to furnish the information within three business days of a patient requesting an estimate or scheduling a service.

For providers who are eligible to ask a patient for a consent waiver, the provider must generally notify the patient in writing 72 hours before services are scheduled to be delivered. This notification must include a good faith cost estimate and identify available in-network options for obtaining the service. The notice must contain at least the following information: notification that the provider is out-of-network; a good faith estimate of the charges; a list of in-network providers at the facility (if the facility is in-network) to which the patient can be referred; information on any prior authorization or other care management requirements; and a clear statement that consent is optional and that the patient can instead opt for an in-network provider. The HHS Secretary must issue further guidance on these requirements by July 1, 2021, including specifying the form to document patient consent.

An out-of-network provider can balance bill a patient for elective items or services if they satisfy the notice and consent requirements of the law. The notice and consent process cannot be used for certain services, including certain ancillary services, and items or services that are delivered as a result of an unforeseen urgent medical need that arises during a procedure for which notice and consent was received.

Ancillary Services for Which Notice and Consent Option Does Not Apply.

Patients receiving the following nonemergency ancillary services may not be billed beyond their in-network cost-sharing amount without regard to the existence of a signed consent:

- Items and services related to emergency medicine, including anesthesiology, pathology, radiology, neonatology, diagnostic services (including radiology and laboratory services);

- If there is no in-network provider available to furnish the item or service at the facility.

Provider Disclosure of Balance Billing Protections.

All healthcare providers must make information on patients' rights with respect to balance billing publicly available. This notice should also be available on the providers' public websites. The notice must contain information on the requirements established under the law, information on any state-level protections if applicable, and contact information for state and federal agencies to report any potential violations.

The legislation also allows certain providers to request that a patient sign a consent waiver. But this exception is relatively narrow and generally more protective of consumers than state laws that allow for consent waivers. This exception is only allowed in nonemergency situations.

B. New York Transparency Requirements

The New York state law includes separate disclosure requirements for hospitals and other healthcare providers. While the requirements are different and detailed, they are generally intended to impart network status, identification of affiliated providers, and either pricing information or a method to obtain pricing information.

The New York law also requires consents for elective services. The law refers to "explicit written consent of the insured acknowledging that the participating physician is referring the insured to a non-participating provider and that the referral may result in costs not covered by the health care plan..." Presumably, similar language would apply to services in a participating facility. To preserve its right to pursue a balance from the payer, non-participating providers billing a patient for emergency services should include an assignment of benefits (AOB) form and a claim form for a third-party payor with the patient's bill.

If there is advance consent as described above prior to the provision of non-emergency services, the limits on balance billing the patients would not apply. Aside from the consent requirement, disclosure requirements apply. Absent the required consent and disclosure, the bill would be considered a 'Surprise Bill' and subject to the limits on the ability to balance bill.

C. New Jersey Transparency Requirements

The transparency provisions of the New Jersey state law apply to all carriers operating in New Jersey with regards to health benefits plans that are issued in New Jersey. Carriers are required to:

- Maintain up-to-date website postings of network providers;
- Provide clear and detailed information regarding how voluntary out-of-network services are covered for plans that feature out-of-network coverage;
- Provide examples of out-of-network costs;
- Provide treatment-specific information as to estimated costs when requested by a covered person; and
- Maintain a telephone hotline to address questions.

Dispute Resolution

A. Federal Arbitration Process

Under the No Surprises Act, insurers and providers have 30 days to negotiate payment disputes. If negotiations fail, either party may, within four days, request independent dispute resolution.

The arbitration process will be administered by independent dispute resolution entities subject to conflict-of-interest standards. The federal government will establish the independent dispute resolution process, including a list of entities available to take cases.

Like the New Jersey law, the No Surprises Act adopts "baseball-style" arbitration rules: each party offers a payment amount, and the arbitrator selects one amount or the other with no ability to split the difference. The decision is then binding on the parties, although the parties can continue to negotiate or settle. Multiple cases involving the same provider, payer, treatment of the same or similar medical condition, that have occurred within a single 30-day period can be combined in a single arbitration proceeding.

The losing party will be responsible for paying the administrative costs of arbitration.

Arbitration Factors.

Arbitrators can consider a range of factors, including any relevant factors raised by the parties, but not the provider's usual and customary charge or the billed charge. Optional factors that an arbitrator can consider include the level of training or experience of the provider or facility; the quality and outcomes measurements of the provider or facility; market share held by the out-of-network healthcare provider or facility, or by the plan or issuer in the geographic region in which the item or service was provided; patient acuity and complexity of services provided; teaching status, case mix, and scope of services of the facility; any good faith effort—or lack thereof—to join the insurer's network; and any prior contracted rates over the previous four years. Arbitrators would also be able to consider the median in-network rate paid by the insurer.

B. New Jersey Arbitration Process

New Jersey has contracted with MAXIMUS, Inc. to administer its Out-of-Network Arbitration System. Like the New York law, New Jersey's law is limited to fully insured payer

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contracts. However, self-funded plans may be subject to the claims processing and arbitration provisions and be subject to the same arbitration process as carriers in the insured markets.

An out-of-network provider has 30 days to contact the carrier to negotiate a final reimbursement amount if the provider does not accept the carrier's determination as payment in full. If a settlement is reached, the carrier must remit the additional payment to the out-of-network provider within 30 days. If no settlement is reached in that 30-day negotiation period, the carrier must pay its final offered reimbursement amount to the out-of-network provider within 7 days, assuming the carrier offered an amount higher than its initial allowed charge.

After that, either party may submit a request for a binding "baseball-style" arbitration to MAXIMUS, the New Jersey Department of Bank and Insurance's (DOBI) out-of-network arbitration vendor, provided that (i) the difference between the carrier's final offer and the provider's final offer is equal to or greater than $1,000, and (ii) the matter does not involve a dispute regarding the characterization of services. Arbitration does not apply in situations where a patient knowingly, voluntarily, and specifically selected an out-of-network provider.

A self-funded plan may opt to be subject to the claims processing and arbitration provisions and to be subject to the same arbitration process as carriers in the insured markets.

Fears of arbitration should not worry providers too much. A study published in the January 2021 edition of *Health Affairs* analyzed 1,695 surprise billing arbitration cases that were filed and completed in New Jersey in 2019. The study found that the median decision resulted in awards 5.7 times the prevailing in-network rates for the same services. The four most common specialties that participated in arbitrations in New Jersey were orthopedics, general surgery, plastic surgery, and trauma and emergency medicine.

C. New York Alternate Dispute Resolution

If a patient signs an AOB form for an emergency service, or for a "Surprise Bill' as defined above, the physician cannot balance bill the patient beyond their in-network cost-sharing. The payer, however, is required to pay the non-participating provider the billed amount or attempt to negotiate reimbursement. If the patient was sent, but did not sign, the AOB, the non-participating physician can bill the patient, who will be responsible for disputing any amount unpaid by the insurer.

If the physician and payer cannot resolve the appropriate payment amount pursuant to the AOB, the payer is required to pay an amount that is 'reasonable.'

An independent dispute resolution program has been established by New York to dispute the payer's determination of what is reasonable, with some exceptions. Providers would make application for dispute resolution through the New York Division of Financial Services, which will assign the matter to an Independent Dispute Resolution Entity.

Penalty Provisions

With respect to providers, the No Surprises Act allows states to require a provider to comply with the new standards and contains enforcement provisions similar to those under the Affordable Care Act and HIPAA. That is, states will continue to regulate fully insured group medical plans and the Department of Labor will regulate self-insured plans. The federal enforcement provisions provide for civil monetary penalties up to $10,000 per violation and the creation of a federal process to receive consumer complaints related to surprise medical bills.

Conclusion

Providers caring for patients outside of the patient's health plan network should educate themselves in the requirements that presently and in the future will impact the amount and ability to get paid for their services. Requirements impacting balance billing, transparency, and alternate dispute resolution continue to evolve, and an added level of federal requirements promises to continue to change the landscape into the foreseeable future.

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