Surprise! It's the No Surprises Act

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Posted By: Kelly J. Noyes

Practice Area: Health Law & Healthcare Billing and Collection

In January 2022, a new law goes into effect limiting "surprise" medical bills, or bills insured patients receive for out-of-network care, either in emergency settings, or from out-of-network providers at in-network facilities. Congress passed the No Surprises Act as part of the 2020 year-end omnibus spending bill and, while many details of the No Surprises Act are still forthcoming as federal agencies engage in the necessary rulemaking (which may not be complete by the Act's effective date), health care providers, facilities, insurers, and health plans should act now to ensure they are ready to comply with the Act's requirements.

What is surprise billing?
In the context of the No Surprises Act, a "surprise bill" occurs when a health care provider or facility balance bills a patient the difference between the facility or provider's billed charges, and a health plan's out-of-network benefit. These bills are often a surprise because the patient either was not able to choose whether to use an in-network or out-of-network facility or provider, or was not aware that the provider was out-of-network until after the services were rendered.

For example, if a patient is injured in an accident and is unconscious, the patient may be taken to an out-of-network emergency room. Another example is when a patient chooses an in-network facility and an in-network primary provider, but is unaware that other providers, such as anesthesiologists, or specialists brought in to address complications, are not in-network. In both scenarios, patients can end up with large, out-of-network bills through no fault of their own.

What kind of care and treatment does the No Surprises Act apply to?
The No Surprises Act imposes requirements on health care facilities, providers, and group health plans or health insurance issuers offering group or individual health insurance coverage in three major areas:

1. Emergency Services.
Under the No Surprises Act, a health plan that provides emergency coverage must provide that coverage without prior authorization, without regard to whether a facility is in-network or out-of-network, and regardless of other terms of the plan, except for exclusions or coordination of benefits. Health plans also cannot deny claims for emergency coverage based on an after-the-fact assessment of the care provided, any purported delay between when symptoms began and when the patient sought care, or based on how long the symptoms were present.

Emergency health care facilities (including independent, freestanding emergency rooms and urgent care centers licensed to provide emergency care) also cannot balance bill patients for out-of-network emergency care. Instead, patient's bills are limited to the same cost-sharing as for in-network emergency care, and any patient payments must apply to the patient's deductibles and out-of-pocket maximums.

Emergency care also includes post-stabilization services, or services and items provided as part of outpatient observation or inpatient or outpatient stay with respect to emergency visits. Only after a patient is stable and can be moved to an in-network facility using non-medical transport (as determined by the patient's treating provider) can a facility or provider seek the patient's consent to paying out-of-network rates (as described below).

2. Non-emergency services provided by out-of-network providers at in-network facilities.
The No Surprises Act also prohibits out-of-network providers from balance billing patients for services provided at in-network facilities. For this restriction to apply, the facility has to have a contractual agreement with the patient's health plan. It does not apply to out-of-network facilities.

This surprise billing situation often arises in the context of ancillary services, or services provided by professionals the patient does not choose, such as anesthesiologists or radiologists.

It can also apply when a health plan enters into a special arrangement with a health care facility to provide certain specialized care in-network, but does not reach a similar agreement with all of the providers at that facility.

3. Air Ambulance Services.
The No Surprises Act also bars balance billing for out-of-network air ambulance services, but not services provided by ground ambulance. Air ambulance services are expensive, and often provided on an out-of-network basis.

Can patients waive the No Surprises Act's protections?
The No Surprises Act allows patients to waive its protections with regard to certain non-emergency services only, but there are strict notice and consent requirements that apply. These requirements make it clear that Congress's intention is that waiver of the No Surprises Act protections and consent to payment of out-of-network fees should be the exception for patients, rather than the rule.

Besides not applying to emergency services, the rules regarding waiver also do not apply to ancillary services, including emergency medicine, anesthesiology, pathology, radiology, and neonatology; items and services provided by assistant surgeons, hospitalists, and intensivists; diagnostic services; and nonparticipating providers if there is no participating provider option.

Patients also cannot agree to waive out-of-network care for any complications that may arise, for example, during a surgical procedure, that would require assistance from an out-of-network provider.

If a patient declines to waive the No Surprises Act protections, an out-of-network provider can refuse to provide treatment, unless there is no in-network option, or there is another law barring such a refusal. However, the provider cannot pressure a patient into waiving their rights, including by delaying necessary treatment, or charging cancellation fees for existing appointments.

What do health care providers and facilities need to do?
Although many of the details of how the No Surprises Act will be implemented are still forthcoming, health care facilities and providers should begin work to ensure that they are ready to fulfill the Act's requirements beginning in January 2022. This includes the following:

1. Public Disclosures.
The No Surprises Act requires health care facilities and providers to provide – to both the public and patients with applicable health plans – a one-page disclosure providing a plain-language explanation of the No Surprises Act and its requirements. Although more details about the exact requirements of this disclosure are forthcoming, the existing regulations require that the disclosure give patients a clear and understandable statement of the requirements and prohibitions of the No Surprises Act. The disclosure also has to include information regarding the process through which patients can complain about alleged violations.

The disclosure has to be publicly posted, available on a public portion of a provider or facility's website, and be provided to applicable patients prior to the patient receiving a bill.

2. No balance billing out-of-network patients.
Prior to the No Surprises Act, many health care facilities and providers would bill out-of-network patients directly, requiring the patient to seek reimbursement from his or her health plan. The No Surprises Act bars this practice. Instead, facilities and providers must determine what patients are in-network versus out-of-network, and negotiate any payment amounts for out-of-network care with the patient's health plan, rather than billing the patient and requiring the patient to negotiate with the plan. Also, because the amount of the patient payment will be determined using data only available to the plan (as discussed below), health care facilities and providers must rely on the health plan to determine how much the patient owes, rather than billing the patient directly.

Providers, facilities, and health plans that bill patients in violation of the No Surprises Act are subject to civil monetary penalties of up to $10,000. However, such penalties do not apply if the facility or provider does not knowingly violate the law, should not have reasonably known that it violated the law, withdraws the bill within 30 days, and reimburses any payments received plus interest.

3. Where applicable, obtain the necessary written waiver of the Act's protections.
If a provider seeks to have a patient waive the No Surprises Act's protections, the provider has to give the patient a detailed written consent form at least 72 hours prior to a scheduled appointment, or 3 hours before a same-day appointment. More details about the required consent are forthcoming, but the existing regulations require that the consent form be provided to the patient separate from other forms, and indicate: (1) whether pre-authorization is required; (2) what in-network providers are available; and (3) the good-faith cost estimate for the total bills for the proposed out-of-network care.

This third requirement – the good-faith cost estimate – will be the subject of forthcoming rule-making, and will not be immediately enforced in the No Surprises Act. The good faith cost estimate also triggers health plans to provide an advanced explanation of benefits, giving patients information regarding not just the total cost of the out-of-network care, but the patient's likely out-of-pocket expenses.

Patients have to give their consent to out-of-network treatment voluntarily, and can do so on a provider-by-provider, or service-by-service basis. Patients can also withdraw their consent at any time.

Providers and facilities must give patients copies of any consent forms they sign, and keep the forms for seven years. Providers and facilities also must submit the consent forms to patients' health plans.

What do facilities and providers get paid for out-of-network care?
There are two components to the payments provided to out-of-network facilities and providers under the No Surprises Act: patient payments, and health plan payments.

1. Patient Payments.
Under the No Surprises Act, patient payments are limited to the patient's cost-sharing requirement for in-network care. This means, for example, that if a patient's health plan has a 20% coinsurance requirement for in-network emergency care, that same 20% requirement applies to the out-of-network emergency care.

Patient cost-sharing calculations are applied to the lesser of the facility or provider's billed amount or the Qualified Payment Amount, or QPA.

The QPA is the median of the contracted rates recognized by the health plan on January 31, 2019 for the same or similar item or service provided by a similar provider in the same geographic region, and indexed for inflation. Health plans must calculate the QPA using a long series of requirements detailed in the regulations and meant to ensure that the patient cost-sharing is based on a total amount similar to that charged for in-network care. If a health plan does not have enough data to calculate the QPA, it may use an eligible database.

Calculation of the QPA may place a significant burden on health plans, which must compile and analyze a significant amount of data to calculate these amounts. However, the QPA is important not just to assessing the patient's payment obligation, but to determining the reasonableness of the health plan's overall payment and in the dispute resolution process, as described below.

2. Health Plan Payments.
The second component of the payment to facilities or health care providers is the health plan's payment. Health plans must pay the facility or provider the total amount the plan believes it owes within 30 days of receiving a clean claim.

The No Surprises Act provides that plans' payments can be based on an All Payer model, state law, an agreement between the plan and the facility or provider, or a resolution decided by an arbitrator through the independent dispute resolution process. Wisconsin does not recognize an all-payer model.

There are Wisconsin Administrative Code provisions that discuss out-of-network emergency care requirements for defined network or preferred provider plans, Wis. Admin. Code Ins. 9.32, but it is unclear whether those provisions are specific enough with regard to those plans' required payments to facilities or providers to apply under the No Surprises Act.

That means that in Wisconsin, health plan payments under the No Surprises Act will be based on an "agreement" between the plan and the facility or provider. In practice, the plan will pay the facility and provider what it believes it owes, along with a notice providing the QPA and how it was calculated, and a notification of the right to enter into a 30-day negotiation period related to the plan's payment, including contact information for the person at the plan responsible for such negotiations. The health care facility or provider then has to assess whether to accept the plan's payment, or negotiate for a higher amount.

If the health care facility or provider enters into negotiations and cannot reach a resolution within 30 days, the facility or provider then has four days to initiate independent dispute resolution regarding the payment amount.

3. Independent Dispute Resolution (IDR).
If a health care facility or provider initiates the IDR process, both the facility or provider and the health plan will submit to an arbitrator a proposed payment amount, and information regarding the following factors:

- The calculated QPA
- The provider's training and experience
- The complexity of the procedure or medical decision-making
- The patient's acuity
- The market share of the health plan, and the provider or facility
- Whether the care was provided at a teaching facility
- The scope of services
- Any demonstration of good faith efforts to agree on a payment amount; and
- The contracted rates from the prior year

The arbitrator will then choose one of the two proposals as the amount of the payment. Under the current regulations, the arbitrator cannot come up with his or her own payment amount. Arbitrators are paid through fees assessed to the entities that use the IDR process.

Many details about the IDR process related to health plan payments for out-of-network services are forthcoming, including what weight arbitrators should give to each of the factors provided.

How is the No Surprises Act going to be enforced?
States will have primary enforcement authority for the No Surprises Act, both of issuers who offer health insurance coverage in the individual or group markets in the state, and for facilities or providers offering services in the state. If the state does not provide adequate enforcement, the Center for Medicare and Medicaid Services (CMS) will take over enforcement.

With regard to health plans, CMS and states may conduct random, targeted, market conduct investigations to ensure compliance. This includes audits of calculations of the QPA, and other investigations to ensure that consumers are not overpaying, without relying solely on complaints or other information indicating that there has been a violation.

CMS may also conduct random or targeted investigations of providers or facilities.

The enforcing authority must provide notice of a violation, including the information that prompted the investigation, and the potential for a civil monetary penalty or imposition of a plan of corrective action. The violator will typically have 14 days to respond, although that period can be shortened to 24 hours or extended to 30 days or more depending on the circumstances.

The No Surprises Act imposes civil monetary penalties of up to $10,000. In determining what penalty to impose, CMS may consider a variety of factors, including the degree of culpability, history and frequency of prior violations, the impact on affected individuals, the gravity of the violation, and whether any violations have been corrected. The penalty will be waived if a provider or facility does not knowingly violate, and should not have reasonably known it violated, the act, and reimburses any incorrect payments plus interest. There is also a hardship exemption to the civil monetary penalties.

Within 30 days, a provider or facility may request a hearing regarding the civil monetary penalty with an administrative law judge, and may also appeal the ruling of the administrative law judge to the U.S. Court of Appeals for the circuit in which the provider or facilities provides services or where the violation occurred.

What about my other questions?
The No Surprises Act is a complicated statute, and many details regarding how it will be applied and enforced are still forthcoming.

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