The No Surprises Act

By Milanna Datlow

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Overview of Key Provisions, Implementation, and Enforcement

The federal No Surprises Act ("NSA") was enacted as part of the Consolidated Appropriations Act, 2021 on December 27, 2020. It applies to group health plans (including grandfathered plans), health insurance issuers of group or individual health coverage for plans/policies, and Federal Employees Health Benefits (FEHB) Program carriers.

The NSA provides federal protections against surprise (or balance) billing for three categories of services, all of which have in common the patient's inability to choose a provider. Specifically, the NSA applies to:

- out-of-network emergency services;
- non-emergency services furnished at in-network facility by an out-of-network provider without the patient knowingly electing that provider or giving consent to be billed; and
- out-of-network air ambulance services.

Balance billing refers to the practice of out-of-network providers billing patients for the difference between: (1) the provider's billed charges, and (2) the amount collected from the plan or issuer plus the amount collected from the patient in the form of cost-sharing (such as a copayment, coinsurance, or amounts paid toward a deductible).

The Departments of the Treasury, Labor, and Health and Human Services (the "Departments") and the Office of Personnel Management (the "OPM") issued implementing regulations for the NSA's provisions: two parts of Interim Final Rules ("IFR") in July 2021 (July 2021 IFR) and in October 2021 (October 2021 IFR), and Final Rules ("FR") in August 2022, which became effective on October 25, 2022.

Summary of the Interim Final Rules Implementing the NSA

July 2021 IFR

A patient's cost-sharing amounts for the non-air ambulance services subject to the NSA is limited to the "recognized amount," which is:

- if the state has an All-Payer Model (APM) Agreement, the amount under such agreement; or
- if there is no such applicable APM Agreement, an amount determined by state law; or
- if neither of the above apply, the lesser of the billed charge or the plan's or issuer's median contracted (in-network) rate, referred to as the qualifying payment amount (QPA), for the service in the geographic region.

An APM Agreement is an agreement between the Centers for Medicare & Medicaid Services and a state to test and operate systems of all-payer payment reform for the medical care of residents of the state. With respect to the QPA, the Departments (or applicable state authorities) are responsible for conducting audits of the plan's or issuer's QPA calculation methodology to ensure its accuracy.

The NSA's cost-sharing protections also apply to air ambulances but there is no "recognized amount" because states are preempted from regulating these providers under the Airline Deregulation Act. Under the NSA, cost-sharing amounts for their services must be based on the lesser of the billed charge or the QPA.

When the QPA serves as the cost-sharing amount, plans and issuers are required to make disclosures about the

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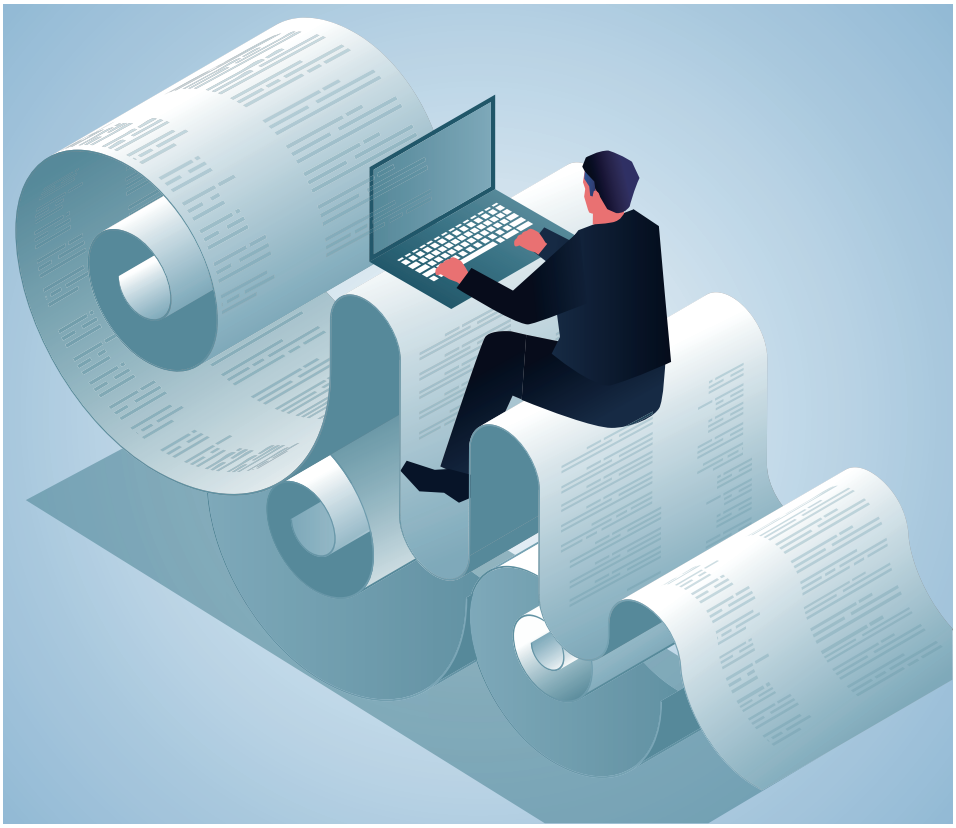

QPA with each initial payment or notice of denial of payment and provide additional information upon request of the provider or facility. Providers are banned from sending patients balance bills for any amounts beyond the cost-sharing.

The total amount paid by a plan or issuer for the services subject to the NSA, referred to as the "out-of-network rate," must be equal to one of the following amounts, less any cost-sharing payments:

- an amount determined by an applicable APM Agreement; or
- if there is no such applicable APM Agreement, an amount determined by state law; or
- if there is no state law determined rate, an agreed upon rate; or
- if no agreement is reached, an amount determined by the newly created federal independent dispute resolution ("IDR") process.

For example, if the out-of-network rate for a non-air ambulance service is determined to be $1,500 and the "recognized amount" for the service is determined to be $1,000, the plan is required to pay $500 (the difference between the out-of-network rate and the cost-sharing amount) and the patient is required to pay $1,000, even if the patient has not yet paid any of the plan's deductible which is higher than $1,000, because the patient's out-of-pocket costs are limited to the cost-sharing amount calculated using the recognized amount.

October 2021 IFR

If the provider or the facility disagrees with the payment for the service subject to the NSA, there is a mandatory 30-day negotiation period. If negotiations do not result in an agreement by the end of the negotiation period, the parties have four (4) days to request that the IDR process determine the rate. Each party submits their best offer to the independent arbitrator, who must choose one or the other (arbitrator cannot split the difference).

The NSA recognizes that lack of standards for payment determinations may result in large awards to facilities and providers and, consequently, increased premiums. Therefore, it limits the factors arbitrators may consider in making decisions.

The IDR entity may not consider any information submitted by the parties concerning the following *prohibited factors:*

- usual and customary charges, also known as the UCR amount, referring to the amount providers in a geographic area usually charge for the same or similar medical service;
- the amount that would have been billed if the services were not subject to the NSA; and
- rates payable in public sector programs, such as Medicare and Medicaid.

The IDR may consider a*llowed factors*, which include:

- training, education, and experience of the provider;
- market share in the geographic region where the service was provided held by the out-of-network provider, facility, the plan, or the issuer;
- patient acuity or complexity of the service;
- teaching status and scope of services of the out-of-network facility;
- good faith efforts made by the out-of-network facility or provider to join the network; and
- prior contracted rates between the provider or facility and the plan or issuer, if applicable, during the previous four (4) plan years.

The October 2021 IFR required that IDR entities apply a "rebuttable presumption" in favor of the QPA, *i.e.*, select the offer closest to the QPA, unless the additional information submitted by either party on the allowed factors "clearly demonstrated" that the QPA was "materially different" from the appropriate out-of-network rate. Such mandatory deference to the QPA in the out-of-network rate determination process has been aggressively challenged by providers in court.

In particular, on October 28, 2021, the Texas Medical Association, a trade association representing physicians, and a Texas physician filed a lawsuit against the Departments and the OPM, asserting that the October 2021 IFR ignored Congress's intent that IDR entities should not favor any single allowed factor in determining the out-of-network rate related to non-air ambulance services. Plaintiffs argued that the NSA requires that the IDR entity always consider the QPA without the parties

specifically bringing it to its attention *and* consider "additional information" or "additional circumstances" if the parties choose to submit that as part of their offer. On February 23, 2022, the United States District Court for the Eastern District of Texas (the "District Court") vacated applicable portions of the October 2021 IFR. *Tex. Med. Ass'n v. U.S. Dept. of Health and Human Servs.,* Case No. 6:21-cv-425 (E.D. Tex. 2022).

In addition, on April 27, 2022, LifeNet, Inc., a provider of air ambulance services, filed a lawsuit against the Departments and the OPM seeking vacatur of the requirement in the October 2021 IFR that the IDR entity may consider information submitted by a party only if the information "clearly demonstrate[s] that the qualifying payment amount is materially different from the appropriate out-of-network rate." On July 26, 2022, the District Court issued an order vacating this language. *LifeNet, Inc. v. U.S. Dep't of Health and Human Servs., et al.*, Case No. 6:22-cv-162 (E.D. Tex.).

Summary of the Final Rules Implementing the NSA

The FR removes the language vacated by the District Court and finalizes parts of the July 2021 and October 2021 IFR related to (1) the information that must be disclosed about the QPA to address downcoding, (2) the certified IDR entity's consideration of the statutory factors when making a payment determination, and (3) the IDR entity's written decision explaining the rationale for its out-of-network rate determination in *all* cases.

"Downcoding" means the alteration by a plan or issuer of a service code to another service code, or the alteration, addition, or removal of a modifier, if the changed code or modifier is associated with a lower QPA than the service code or modifier billed. If a QPA is based on a downcoded service code or modifier, in addition to the information already required to be provided with an initial payment or notice of denial of payment, a plan or issuer must provide (1) a statement that the billed service code or modifier was downcoded, (2) an explanation of why the claim was downcoded, including a description of which service codes were altered, if any, and which modifiers were altered, added, or removed, if any, and (3) the amount that would have been the QPA had the service code or modifier not been downcoded.

The IDR entity is required to consider the QPA and the permissible additional information when determining the out-of-network rate, without defaulting to the offer closest to the QPA or applying a presumption in favor of that offer. Rather, the IDR entities must select the offer that best represents the value of the service under dispute after considering the QPA and all permissible information submitted by the parties. The FR explain that the QPA is a quantitative figure that often represents an appropriate out-of-network rate, as the QPA calculation methodology already incorporates the qualitative factors that affect costs, including medical specialty, geographic region, and patient acuity and case severity, and considering the same factors twice would be redundant. Nonetheless, the FR acknowledge that there are instances where certain factors affecting the value of a particular service may not be adequately reflected in the QPA, but are relevant in determining the appropriate out-of-network rate.

The FR provide the following examples illustrating the IDR entity's payment determination process:

Example 1. (i) Facts: A level 1 trauma center that is an out-of-network emergency facility and an issuer are parties to a payment determination. The facility submits an offer that is higher than the QPA and additional information showing that the scope of services available at the facility was critical to the delivery of the provided service, given the particular patient's acuity. The facility also submits additional information showing the contracted rates used to calculate the QPA for the service were based on a level of service that is typical in cases in which the services are delivered by a facility that is not a level 1 trauma center and that does not have the capability to provide the scope of services provided by a level 1 trauma center.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the facility, which relates to the service that is the subject of the payment determination. If the IDR entity determines that the additional information about the scope of services submitted by the facility demonstrates that the facility's offer best represents the value of the service, the certified IDR entity should select the facility's offer as the appropriate rate.

The NSA recognizes that lack of standards for payment determinations may result in large awards to facilities and providers and, consequently, increased premiums.

Example 2. (i) Facts: An out-of-network provider and an issuer are parties to a payment determination. The provider submits an offer that is higher than the QPA and additional information regarding the provider's level of training and experience.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the out-of-network provider. However, if the IDR entity determines that the provider's level of training and experience does not relate to the service that is the subject of the payment determination (for example, the information does not show that the provider's level of training and experience was necessary for providing the service to the particular patient, or that the training or experience made an impact on the care that was provided), the IDR entity should select the QPA, which best represents the value of the service.

Example 3. (i) Facts: An out-of-network provider and an issuer are parties to a payment determination involving an

emergency department visit for the evaluation and management of a patient. The provider submits an offer that is higher than the QPA and additional information showing that the acuity of the patient's condition and complexity of the service required the taking of a comprehensive history, a comprehensive examination, and medical decision making of high complexity. The issuer submits an offer equal to the QPA for CPT code 99285, which is the CPT code for an emergency department visit for the evaluation and management of a patient requiring a comprehensive history, a comprehensive examination, and medical decision making of high complexity, and additional information showing that this CPT code accounts for the acuity of the patient's condition. The IDR entity determines that the information provided by the provider and issuer relates to the service that is the subject of the payment determination.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the parties. However, it should not give weight to the additional information on the acuity of the patient and complexity of the service provided by the provider if that information is already accounted for in the calculation of the QPA, and should select the QPA that best represents the value of the service

Example 4. (i) Facts: An out-of-network emergency facility and an issuer are parties to a payment determination. Although the facility is out-of-network during the relevant plan year, it was in-network in the previous four (4) plan years. The issuer submits an offer that is higher than the QPA and additional information showing that the offer is equal to the facility's contracted rate for the previous year with the issuer for the service and that the prior contracted rate took into account the case mix and scope of services typically furnished at the facility. The facility submits an offer that is higher than both the QPA and the prior contracted rate and also submits additional information showing that the case mix and scope of available services were integral to the service provided.

(ii) Conclusion: The IDR entity must consider the QPA and the additional information submitted by the parties, but should not give weight to information to the extent it is already accounted for by the QPA. If the IDR entity determines that the information submitted by the facility regarding the case mix and scope of services available at the facility includes information that is also accounted for in the information that the issuer submitted regarding prior contracted rates, then the IDR entity should give weight to that information only once. If the IDR entity determines that the issuer's offer (prior contracted rate) best represents the value of the disputed service, the IDR entity should select the issuer's offer.

Example 5. (i) Facts: An out-of-network provider and an issuer are parties to a payment determination regarding a service for which the issuer downcoded the service code that the provider billed. The issuer submits an offer equal to the QPA (calculated using the downcoded service code) and additional information including the documentation disclosed to the out-of-network provider at the time of the initial payment (which describes why the service code was downcoded). The out-of-network provider submits an offer equal to the amount that would have been the QPA had the service code not been downcoded and additional information that explains that the billed service code was more appropriate than the downcoded service code due to the complexity of the service, as evidence that the QPA for the service code that the provider billed best represents the value of the service.

(ii) Conclusion: The IDR entity must consider the QPA, which is based on the downcoded service code, and then must consider whether to give weight to additional information submitted by the parties. If the IDR entity determines that the additional information submitted by the provider demonstrates that the provider's offer best represents the value of the service, the IDR entity should select the provider's offer.

After the IDR entity has selected an offer, it must explain its determination in a written decision and submit it to the parties and the Departments. The written decision must explain what information the IDR entity determined demonstrated that the offer selected is the out-of-network rate that best represents the value of the service. This explanation must include the weight given to the QPA and any additional non-prohibited, credible information submitted. If the IDR entity relies on any additional information in selecting an offer, the written decision must explain the conclusion that this information was not already reflected in the QPA.

For calendar year 2023, certified IDR entities may charge $200 to $700 for single determinations and $268 to $938 for batched determinations. See ***https://www.cms.gov/cciio/resources/regulations-and-guidance/downloads/cy2023-fee-guidance-federal-independent-dispute-resolution-process-nsa.pdf***. Loser pays the cost of the arbitration.

Implementation and Enforcement of the NSA

Currently, there are 33 states with existing laws protecting consumers against surprise medical bills. Jack Hoadley, et al., *No Surprises Act: A Federal-State Partnership to Protect Consumers from Medical Bills*, The Commonwealth Fund (Oct. 20, 2022). Where state laws have a narrower scope than the NSA, the NSA expands consumer protections. However, some state laws have a broader scope than the NSA, *e.g.*, include protections for additional services such as ground ambulance services. *Id.* As long as state balance billing laws do not prevent the application of the NSA's protections, the NSA does not preempt them.

The NSA fills in gaps left by existing state law protections, including where federal laws preempt state action. Specifically, if the state has no applicable APM Agreement, state balance billing laws, if they exist, apply to the determination of the recognized amount and the out-of-network rate only when the insurer/plan, the provider and the facility are within the state jurisdiction. Typically, this includes fully insured plans but not employer-sponsored self-funded plans because ERISA preempts state laws with respect to self-funded group health plans and prohibits states from regulating a self-funded plan as insurance. Similarly, the Airline Deregulation Act preempts state laws with respect to air ambulances. The NSA provides

nationwide protections in both of these circumstances.

The following examples in the July 2021 IFR illustrate how state laws may or may not apply. Each example assumes there is no applicable APM Agreement that would determine the recognized amount or out-of-network rate.

Example 1. (i) Facts. A health insurance issuer licensed in State A covers a specific non-emergency service that is provided to an enrollee by an out-of-network provider in an in-network health care facility, both of which are also licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by out-of-network providers in an in-network health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The state law applies to health insurance issuers and providers licensed in State A. The state law also applies to the type of service provided.

(ii) Conclusion. State A's law would apply to determine the recognized amount and the out-of-network rate.

Example 2. (i) Facts. Same facts as Example 1, except that the out-of-network provider and in-network health care facility are located and licensed in State B. State A's law does not apply to the provider, because the provider is licensed and located in State B.

(ii) Conclusion. State A's law would not apply to determine the recognized amount and out-of-network rate. Instead, the lesser of the billed amount or QPA would apply to determine the recognized amount, and either an amount determined through agreement between the provider and issuer or an amount determined by an IDR entity would apply to determine the out-of-network rate.

Example 3. (i) Facts. An individual receives emergency services at an out-of-network hospital located in State A. The emergency services furnished include post-stabilization services that are within the scope of the NSA. The individual's coverage is through a health insurance issuer licensed in State A, and the coverage includes benefits with respect to services in an emergency department of a hospital. State A has a law that prohibits balance billing for emergency services provided to an individual at an out-of-network hospital located in State A and provides a method for determining the cost-sharing amount and total amount payable in such cases. The law applies to issuers licensed in State A. However, State A's law has a definition of emergency services that does not include post-stabilization services.

(ii) Conclusion. State A's law would apply to determine the cost-sharing amount and out-of-network rate for the emergency services, as defined under State A's law. State A's law would not apply for purposes of determining the cost-sharing amount and out-of-network rate for the post-stabilization services. Instead, the lesser of the QPA or billed amount would apply to determine the recognized amount, and either an amount determined through agreement between the hospital and issuer or an amount determined by an IDR entity would apply to determine the out-of-network rate, with respect to post-stabilization services.

Example 4. (i) Facts. A self-insured plan, subject to ERISA, covers a specific non-emergency service that is provided to a participant by an out-of-network provider in an in-network health care facility, both of which are licensed in State A. State A has a law that prohibits balance billing for non-emergency services provided to individuals by out-of-network providers in an in-network health care facility, and provides for a method for determining the cost-sharing amount and total amount payable. The law applies to health insurance issuers and providers licensed in State A, and provides that plans that are not otherwise subject to the law may opt in. The law also applies to the type of service provided. The self-insured plan has opted in.

(ii) Conclusion. State A's law would apply to determine the recognized amount and the out-of-network rate.

The NSA anticipates that states have the primary enforcement role, to ensure that the plan or issuer actually pays the provider the correct amount determined either by state law or by the IDR entity. But initially most states will partner with federal agencies or rely entirely on federal enforcement. Hoadley, *supra*.

Conclusion

The main goal of the NSA is to protect consumers against balance billing when treated without their knowledge or consent by out-of-network providers or at out-of-network health care facilities. Significantly, however, the scope of the NSA's application is limited to only three distinct categories of out-of-network health care services. Accordingly, as the first step, it is necessary to determine whether the NSA's protections apply to the service at issue.

Another important goal of the NSA is to shield consumers from ever-higher health insurance premiums and to limit cost-sharing costs. To bring certainty to the out-of-network provider rate and cost-sharing determination with respect to the services it governs, the NSA establishes a methodology that defers to the applicable APM Agreement or, if does not exist, to the state law. However, not all states have laws protecting consumers against surprise medical bills. Furthermore, existing state laws do not apply to self-funded plans, out-of-state facilities and providers who are not licensed in the state.

If state law does not exist or apply, the NSA creates a mechanism – a federal IDR process - for resolution of out-of-network provider rate disputes with respect to the services subject to its provisions. The IDR entity must consider the QPA and the permissible additional information, if the parties choose to submit it as part of their offer, and select the offer that best represents the value of the disputed service.

Deference to the QPA, which often incorporates the qualitative factors affecting the value of a particular service, is the most straightforward way to determine the appropriate out-of-network rate. Nonetheless, providers have been challenging in court the rules as to how the QPA should be considered in IDR determinations. *See* Katie Keith, *The Six Provider Lawsuits over the No Surprises Act: Latest Developments,* Health Affairs Forefront (Feb. 16, 2022); Katie Keith, *Health Care Providers Fight Arbitration Rule in No Surprises Act,* To the Point, The Commonwealth Fund (Mar. 17, 2022); and Katie Keith, *Providers Sue (Again) Over No Surprises Act*, Health Affairs Forefront (Sept. 27, 2022). While the FR addressed issues raised in the litigation, some litigation remains active, and further changes could curtail the cost-containment goals of the NSA. Accordingly, until the final resolution of pending lawsuits, providers and payors should maintain records of all permissible additional information relating to the services subject to the NSA.