Westlaw Today
powered by Reuters

Bracing for the impact of the No Surprises Act

By Ed Kornreich, Esq., Matthew Westbrook, Esq., and Angela Gichinga, Proskauer Rose LLP

JUNE 16, 2022

The federal No Surprises Act (NSA) and its implementing regulations[1] are meant to protect against surprise medical bills that often occur when a patient receives services at a health care facility[2] by providers that are "out-of-network" (OON) from the patient's health insurance plan (Plan).

While it is clear that patients ultimately benefit from the NSA's requirements — lower OON charges, increased transparency relating to charges, and appeal rights in certain circumstances — all providers and facilities will face substantial administrative burdens and many will receive lower payment rates.

Problematic pre-NSA environment

Federal law requires a hospital to provide appropriate screening and treatment to a patient presenting to that hospital's emergency department (ED) regardless of the patient's health insurance status or ability to pay for the items and services provided.[3]

While it is clear that patients ultimately benefit from the NSA's requirements, all providers and facilities will face substantial administrative burdens and many will receive lower payment rates.

Before the NSA was enacted, if the patient was either uninsured or covered by a Plan in which either the facility and/or the providers that furnished the items and services to the patient did not participate (*i.e.*, either or both were OON), then the facility and/or the providers were allowed to charge the patient the full price of the items and services furnished to that patient.[4]

Along a similar vein, if a patient received items and services in a non-emergency context (*i.e.*, on an elective basis) at an in-network facility by OON providers (often unbeknownst to the patient), those OON providers were allowed to charge the patient for the full price of the items and services furnished.

While negotiations between the Plan and provider often resulted in relatively high reimbursement rates, for patients receiving items and services in both of these contexts, what came next was often financially crippling — a "surprise" bill for non-covered charges.

Over the past decade, many states have adopted laws preventing or limiting the effect of surprise bills resulting from providers and facilities' "balance billing" practices.[5] But, until the NSA, there was no national response.

A solution without surprises

The NSA provides a congressional solution to the problem. Effective January 1, 2022 (with some exceptions),[6] patients that are uninsured, covered by an ERISA plan, or have commercial health insurance plans[7] must be provided with advance notice about their rights relating to the items and services they receive. The NSA requires facilities to publicly post a statement relating to such rights on their website and on-site, along with distributing the statement directly to patients. Further, if a patient is treated in an OON facility on an emergency basis, that patient is not responsible for and may not be billed any OON charges, including any services that are tied to the emergency services.

In essence, under the NSA, patients must be treated by the OON facility and providers as if the patient were in-network under the Plan. To calculate the payment to the facility and providers as if the patient were in-network, the Plan makes an initial payment to the facility and/or providers, generally representing the median contracted rate paid by the Plan for a specific item or service to facilities in that geographic area — the "Qualifying Payment Amount" (QPA). The patient's co-pay, if any, is based on the QPA.

Over the past decade, many states have adopted laws preventing or limiting the effect of surprise bills resulting from providers and facilities' "balance billing" practices. But, until the NSA, there was no national response.

If, after receiving the initial payment from the Plan, the facility and/or other provider is not satisfied with the QPA, they may challenge the adequacy of the rate by directly negotiating with the Plan. If such negotiations fail, the mandatory, independent dispute resolution (IDR) process may be initiated.

Under the IDR process, a neutral arbiter is tasked with resolving the dispute and may consider the following factors to assess the appropriate OON rate:

(1) the QPA,

(2) the level of training, experience, and outcome measurements of a provider or facility,

(3) the market share held by the OON provider or facility, or the Plan,

(4) patient acuity or the complexity of furnishing a particular item or service,

(5) teaching status, case mix, and scope of services of the OON facility,

(6) demonstrations of good faith efforts made by the OON provider, facility, and/or Plan to enter network participation agreement between the provider or facility and the Plan, and

(7) any other credible and relevant information submitted by either party.[8]

Notwithstanding the enumeration of these factors in the NSA without suggesting any is more important than another, the regulations implementing the NSA create a presumption that the QPA is the appropriate OON rate. So far, this presumption has been successfully challenged.

Although altruistic in its intent, the NSA appears, for now, to present a substantial burden on providers.

In *Tex. Med. Ass'n and Adam Corley v. U.S. Dep't of Health and Hum. Servs.*, et al.,[9] the United States District Court for the Eastern District of Texas (Court) held that the QPA presumption conflicted with the NSA and that the federal agencies had overstepped their regulatory rulemaking authority when the QPA presumption was created without an appropriate notice-and-comment period. Consequently, the Court vacated the requirement that the QPA serve as the presumptive amount in the IDR process, but preserved the remaining aspects of the regulations implementing the NSA.[10] On April 22, 2022, the federal agencies filed a notice to appeal the Court's decision and subsequently asked for and were granted a stay pending the United States Department of Health and Human Services' issuance of a final rule early this summer that will supersede the challenged portions of the implementing regulations.[11] Consistent with the Centers for Medicare & Medicaid Services' (CMS) recently-published revised guidance (see below), the QPA presumption is not anticipated to be included in the final rule.

Recognizing the likely outcome on appeal, and before the federal agencies had filed their notice to appeal, CMS published revised guidance in response to the Court's decision, stating that neutral arbiters must consider the QPA and information that providers and health insurance plans submit during the IDR process, without suggesting that the QPA is presumptively the appropriate payment amount. CMS also re-emphasized that providers are required to prove that, where status factors may be considered to justify a rate in excess of the QPA,[12] such factors were actually material to the items and services provided to the patient.[13] Lastly, CMS clarified that the neutral arbiter has no responsibility to actually validate or verify the QPA. Any questions the neutral arbiter has about the QPA are to be directed to the federal government.

For patients with health insurance plans receiving items and services on an elective basis, facilities and providers are now required to provide good faith estimates (GFEs) of the items and services to be furnished to the patient to Plans, which, in turn, are required to provide the patient with an Advanced Explanation of Benefits (AEOB). AEOBs explain how the Plan will pay for such items and services to be furnished and are required to be provided to patients if they request a copy or when the patient schedules an appointment to receive an elective item or service. While most of the NSA is already effective, the implementation of the AEOB requirement has been deferred until January 1, 2023.

Moreover, OON providers that furnish items and services at in-network facilities are now required to provide patients with notice and to seek those patients' consent on a standard federal form before furnishing such items and services. That federal form provides information relating to the expected charges for the items and services furnished and, most importantly, requires the patients' consent to be charged at the higher, OON rate. Only after a patient is provided with this information and provides consent to receive items and services by the OON provider, may that OON provider furnish and subsequently charge for such items and services. Such consent may only be given when the patient is not in an emergent condition and is able to travel to another provider. And such consent is not applicable to certain ancillary service providers (*e.g.*, hospitalists, radiologists, anesthesiologists, pathologists, neonatologists) who are forbidden to bill the OON charge.

The NSA also requires that patients that are either uninsured or have a Plan but decide not to use their coverage for the items and services to be received, must be provided a written GFE of the expected charges from the treating facility and co-providers. Similar to the notice and consent process for OON providers and in-network facilities, the GFE must be provided when the patient requests a copy or when the patient schedules an appointment to receive items and services. If, at any time, any of the information relating to the items and services reasonably expected to be provided changes, the provider or facility must provide a new GFE at least one business day before the scheduled appointment.[14] Effective January 1, 2023, the GFE must be provided as a single, comprehensive document that reflects charges from *all* providers and facilities[15] reasonably expected to provide care to the patient.

Moreover, if there is a $400+ delta between the amount expected to be charged on the GFE and the amount actually charged, then patients are entitled to initiate a dispute resolution process within 120 days of receiving the bill. Pursuant to this dispute resolution process, a selected dispute resolution entity (SDRE) will be appointed by CMS to determine the appropriate payment amount

the patient should be charged. When making its determination, the SDRE uses the expected charges in the GFE as the presumed appropriate amounts and the provider and facility may present information relating to the reasons for the delta. Lastly, as a general matter, CMS will defer to pre-existing State provider/patient dispute resolution processes.[16]

What to expect

The NSA places certain requirements upon providers and facilities depending on whether a patient has health insurance coverage and whether a provider and/or facility is in-network or OON. The table, below, provides a helpful list of scenarios relating to whether and to what extent the NSA applies.

The NSA, with or without the QPA presumption, will have a significant impact on provider reimbursement. Pre-NSA, if a provider was in-network, then that provider would provide items and services to more of the Plan's patients but would receive less payment per patient.

By contrast, if a provider was OON, then that provider would likely be paid more per patient while providing items and services to fewer patients (because the provider was OON). Now, because the NSA only requires Plans initially to pay the median amount to all OON providers (albeit subject to the IDR process) the ability of the providers to negotiate any higher amount is significantly diminished.[17] As a result, providers will face declining payments while, at the same time, face an administrative burden in implementing the NSA.

Accordingly, although altruistic in its intent, the NSA appears, for now, to present a substantial burden on providers. Patients will benefit because they will face lower OON costs and be provided transparent information relating to the charges for items and services they will receive. Patients can rest easier knowing that they will no longer be charged OON rates in an emergency or otherwise in a "surprise bill" context for items and services without their prior knowledge and/or consent.

Which leaves the providers and facilities as bearing the brunt of the NSA's burdens. Providers and facilities are specifically left bearing the administrative burden of, in the case of the noticed and consent process for OON patients and the GFEs for uninsured or self-pay patients, seeking consent from patients before furnishing items or services and/or creating a comprehensive list of items and services reasonably expected to be charged to the patient before the provider or facility can even think about being paid.

Although the details of the AEOB process for in-network patients have not yet been established, there is no reason to believe that it will be materially less burdensome than the GFE and notice and consent processes. Likewise, OON providers lose their incentive to negotiate any potentially higher reimbursement with Plans because the NSA now requires payment of only the median amount (subject, of course, to the IDR process) — an amount that could be substantially less than what the OON provider could have negotiated, and may already have had, pre-NSA.

Although the factors to be considered by the neutral arbiter, noted above, include "demonstrations of good faith efforts made by the OON provider, facility, and/or Plan to enter network participation agreement between the provider or facility and the Plan," it is not clear what meaningful impact this will have as the parties' IDR offers will likely reflect the terms offered during negotiations. Thus, it will not be easy to show a lack of "good faith" in negotiations. Consequently, OON providers may be left with additional expenses they may not have otherwise accounted for when preparing their annual or forecasted budgets premised on certain historical revenue assumptions.

If they haven't already, providers and facilities will need to brace themselves for the NSA's impact in the years to come.[18]

Notes

[1] Section 112 of Title I of Division BB of the Consolidated Appropriations Act, 2021; *see also* 86 Fed. Reg. 36872 (July 13, 2021) (The first interim final rule implementing the NSA by the Departments of Treasury, Labor, and Health and Human Services, and the Office of Personnel Management.); 86 Fed. Reg. 55980 (Oct. 7, 2021) (The second interim final rule implementing the NSA.).

[2] The term "health care facility" or "facility" refers to a "facility that furnishes health care services that is subject to the surprise billing protections" of the NSA, such as a hospital (including a hospital's emergency department), urgent care center, or ambulatory surgical center. 86 Fed. Reg. at 55987, n. 19.

[3] Assuming the hospital has a Medicare Participation Agreement with the Department of Health and Human Services, Centers for Medicare & Medicaid Services (CMS), the Emergency Medical Treatment & Labor Act, 42 U.S.C. § 1395dd, applies.

[4] CMS.gov, "Surprise billing & protecting consumers," available at https://go.cms.gov/3vhs7R5 (page last modified, Jan. 14, 2022).

Status of Patient, Provider, and Facility	Does the NSA apply?
Insured patient and in-network provider and facility	No, but patient receives AEOB starting in 2023
Insured patient and OON provider and facility	Yes*
Insured patient, OON provider, and in-network facility	Yes*
Insured patient, in-network provider, and OON facility	Yes*
Uninsured patient or patient elects self-pay	Yes, a GFE must be provided to the patient

*OON provider and/or facility can obtain notice and consent for OON treatment.

[5] For example, in 2014, New York became the first state to pass legislation combating surprise billing. *See* New York State Emergency Medical Services and Surprise Bill Act, codified at N.Y. Fin. Serv. L. § 605 (2014).

[6] As discussed later in this article, implementation of the advanced explanation of benefits requirements and the requirements relating to the single, comprehensive notice and good faith estimate requirements have been deferred until January 1, 2023.

[7] Federal health care programs, as defined at 42 U.S.C. § 1320a-7b(f), among other government health insurance plans, were never subject to surprise billing because their rates for items and services are pre-established and publicly-available, and OON rules generally do not apply. 86 Fed Reg. at 56015.

[8] *Id*. at 55995–8.

[9] No. 6:21-cv-00425-JDK (E.D. Tex., Feb. 22, 2022).

[10] There are at least five other lawsuits pending in the federal district courts for the District of Columbia, Georgia, Illinois, and New York, which challenge either the general constitutionality of the NSA and/or specific requirements of the NSA. *See Ass'n of Air Med. Servs. v. U.S. Dep't Health and Hum. Servs*., No. 1:21-cv-3031 (D. D.C., filed Nov. 16, 2021); *Am. Med. Ass'n v. U.S. Dep't Health and Hum. Servs*., No. 1:21-cv-3231 (D. D.C., filed Dec. 9, 2021); *Ga. Coll. Of Emergency Physicians v. U.S. Dep't Health and Hum. Servs.,* No. 1:21-cv-5267 (N.D. Ga., filed Dec. 23, 2021); *Am. Soc. Of Anesthesiologists v. U.S. Dep't Health and Hum. Servs.,* No. 1:21-cv-6823 (N.D. Ill., filed Dec. 22, 2021); *Haller v. U.S. Dep't Health and Hum. Servs.*, No. 2:21-cv-7208 (E.D. N.Y., filed Dec. 31, 2021).

[11] *Tex. Med. Ass'n and Adam Corley v. U.S. Dep't of Health and Hum. Servs., et al.,* No. 6:21-cv-00425-JDK (E.D. Tex., Apr. 22, 2022), ECF No. 116; *Tex. Med. Ass'n and Adam Corley v. U.S. Dep't of Health and Hum. Servs., et al.*, No. 22-40264 (5th. Cir. May 3, 2022), BL-8.

[12] *See* list items 2–5, discussed two paragraphs above.

[13] CMS.gov, "Federal Independent Dispute Resolution (IDR) Process Guidance for Certified IDR Entities" (April 2022) at 20, available at https://go.cms.gov/3OAMBfp (up-to-date as of May 24, 2022).

[14] A GFE is just that — an estimate provided in good faith. If a provider or facility provides a document with an error or an omission, the provider or facility does not fail to comply with the GFE requirement so long as they acted in good faith, with reasonable due diligence, and took corrective action steps as soon as the error or omission is discovered. 86 Fed. Reg. at 65022.

[15] For purposes of this dispute resolution process involving GFEs, "'facility' includes an institution (such as a hospital or hospital outpatient department, critical access hospital, ambulatory surgical center, rural health center, federally qualified health center, laboratory, or imaging center) in any state in which state or applicable local law provides for the licensing of such an institution, that is licensed as such an institution pursuant to such law or is approved by the agency of such state or locality responsible for licensing such institutions as meeting the standards established for such licensing." *Id.* at 55987.

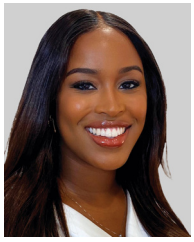
[16] In those states that have adopted their own dispute resolution process, CMS defers to that state's process so long as it meets the minimum requirements of the NSA. *Id.* at 56042–3.

[17] USC-Brookings Schaeffer on Health Policy, "Understanding the No Surprises Act," available at https://brook.gs/3EP3Jti (Feb. 4, 2021) (explaining that, "for [OON] emergency services ... barring surprise [OON] billing creates the need for some sort of price support because these providers are required to treat any patient regardless of ability to pay and thus have no other leverage to draw on in negotiations with payers" and that the NSA's "arbitration process fills that role").

[18] The NSA also applies to air ambulances; however, a discussion about those requirements is beyond the scope of this article.

About the authors





Partner **Ed Kornreich** (L), past long-standing chair of **Proskauer Rose LLP**'s health care department, is an authority on legal, regulatory and business issues related to health care services. He focuses on health care transactions, regulatory compliance, health care payment and governance issues for both for-profit and not-for-profit providers, vendors, group purchasing organizations, distributors and entrepreneurs. He is based in New York and can be reached at ekornreich@proskauer.com. **Matthew Westbrook** (C) is an associate in the corporate department and a member of the health care group. He provides regulatory compliance advice for the firm's health care clients, including service providers, health plans, operators, investors and lenders. He is based in Washington, D.C., and can be reached at mwestbrook@proskauer.com. **Angela Gichinga** (R) is a law clerk in the corporate department and a member of the health care group. She is based in New York and can be reached at agichinga@proskauer.com.

This article was first published on Westlaw Today on June 16, 2022.