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Health reform provisions

No Surprises Act

On Dec. 27, 2020, Congress passed, and President Trump signed, the No Surprises Act as part of the Appropriations bill. The No Surprises Act, which is a law not guidance, goes into effect for plan or policy years beginning on or after Jan. 1, 2022.

The surprise billing legislation establishes federal standards to protect patients from balance billing for defined items and services provided by specified doctors, hospitals and air ambulance carriers on an out-of-network basis. The federal law applies to individual, small group, and large group fully insured markets and self-insured group plans including grandfathered plans. The legislation caps patient cost-sharing for out-of-network items and services at in-network levels and requires providers to work with insurers and health plans to negotiate remaining bills. If the insurer/health plan and the provider are unable to reach agreement, an Independent Dispute Resolution (IDR) process, sometimes called arbitration, was established to determine the reimbursement amount.

There are federal rules and processes yet to be developed, and questions about scope and applicability as it relates to state laws still to be answered. We will continue to update our customers as more is known.

Frequently asked questions (FAQs)

What are some of the key features that are in the No Surprises law?

The No Surprises Act is a law establishing federal standards to resolve surprise bills for the fully insured individual, small group, and large group markets and for self-insured group plans including grandfathered plans for plan and policy years beginning on and after January 1, 2022. The law applies to emergency services at out-of-network (OON) hospitals and free-standing emergency facilities, OON providers at in-network (INN) facilities, and OON air ambulance carriers.

The No Surprises Act establishes an Independent Dispute Resolution (IDR) process, also referred to as arbitration, to resolve disputes between OON providers and insurers/health plans and prohibits balance billing by OON providers with certain exceptions. The law does not apply if the member chooses to receive items and services from an OON provider.

The Departments of Health and Human Services, Labor, and the Treasury will clarify a number of important provisions of the No Surprises Act though rulemaking later this year.

What providers and facilities does the No Surprise Act apply to?

No Surprises Act applies to three types of health care providers and facilities:

1. OON emergency covered items and services.
2. Covered medical items and services performed by an OON provider at an INN facility.
3. OON air ambulance items and services.

How are prior authorization, coverage limits, and member cost-sharing treated for OON services subject to the No Surprises Act?

Insurers/health plan are prohibited from requiring prior authorization for OON emergency services and may not apply coverage limitations for OON emergency services that are more restrictive than those for INN services.

Insurers/health plans cannot apply cost sharing for OON covered items and services that is greater than cost-sharing applied to INN covered items and services (e.g., 10% coinsurance for same INN and OON covered items and services). All OON cost-sharing must be counted toward any INN deductible and cost-sharing limits.

What do payers have to do when they receive a bill for OON services covered by the No Surprises Act?

Insurers/health plans have 30 days after they receive a bill to either pay the “out-of-network rate” directly to the provider or deny the claim. The out-of-network rate is the difference between the member’s cost-sharing amount and the following:

- If the insurer/health plan and OON item or service is covered by a state law that establishes the reimbursement rate, that rate will apply.
- If the state does not have an applicable law, either the amount agreed to by the insurers/health plan and provider or the amount set by the IDR process.
- If the state has an All-Payer Model Agreement, the reimbursement is set by that agreement.

Who can request an Independent Dispute Resolution (IDR)?

Either an insurer/health plan or a provider may request independent dispute resolution. There is a 30-day negotiation period to resolve disputes over reimbursement for OON covered items and services. The negotiation period starts after the provider receives payment or a claim denial as discussed above. Four days after the end of the 30-day negotiation period, either the insurer/health plan or the provider can request an IDR.

How does the IDR process work?

The law includes a measure to have insurers/health plans and providers first try to resolve any payment differences through negotiation on their own. If negotiation does not work, either party may request IDR process, which is a form of arbitration.

- Both the insurer/health plan and the provider will submit an offer along with any documentation supporting their position to the IDR entity, which will choose between them.
- In choosing either the insurer/health plan or provider offer, the IDR can consider certain factors such as the median contracted rate for the disputed items and services, the provider's market share, the provider's training and qualifications, and the severity of the patient's condition.
- When making a decision, the IDR entity cannot consider government program rates (Medicare, Medicaid, Tricare), provider billed charges or usual and customary charges.

Is there a minimum threshold requirement to request dispute resolution?

There is no minimum claim threshold.

Can claims be batched when requesting dispute resolution?

Claims that are related to the original OON covered items and services that were furnished by the same provider within a 30-day period may be combined for purposes of dispute resolution.

Does the No Surprises Act prohibit balance billing?

Yes, in certain cases it may. OON providers are prohibited from balance billing members for emergency services. OON providers at INN facilities are prohibited from balance billing members with certain exceptions.

OON providers of ancillary services at an INN facility are prohibited from balance billing members. Ancillary services are defined by the No Surprises Act as those related to emergency medicine, anesthesiology, pathology, radiology, neonatology, and laboratory and in situations where an INN provider is not available at the INN facility to provide the services.

An OON provider at an INN facility may balance bill members if they are not providing ancillary services and if they give advance notice to the member that the covered item or service is OON and the estimated cost. The member must acknowledge that they received the notice.

How does the balance billing notice provision work?

OON providers at INN facilities that are providing "non-ancillary services" must provide advance notice to members that the services are OON and a good faith estimate of the cost. If the member makes an appointment for the OON services at least 72 hours in advance, the notice must be provided no later than 72 hours before the date of service. If the member schedules the appointment within 72 hours of the date of service, the notice must be provided on the date of service.

The notice may be in writing or electronic at the option of the member. The notice must include the following information:

- That the provider is out-of-network.
- Good faith estimates of the cost for any items and services.
- Consent to obtain OON items and services is voluntary.
- That the member may choose to receive the items or services from an INN provider.
- If applicable, identify INN providers at the facility who can provide the items or services.
- Information about whether prior authorization may be required.

The member must sign an acknowledgement that they received the notice and understand that any cost-sharing will apply to the member's OON deductible and cost-sharing limits and that they will be responsible for any balance bill.

Will the law apply if a member chooses to use an out-of-network provider?

No. The No Surprises Act does not impact claims related to members who choose to use OON providers. Balance billing may continue with those claims.

Does the federal No Surprises Act pre-empt state surprise billing laws?

The law may not pre-empt state surprise billing laws that establish a process for determining OON reimbursement for covered items and services for insurers subject to the state's law.

What insurer and health plan responsibilities are included in the No Surprises Act?

The insurer and health plan have certain responsibilities if a member gets out-of-network notice from a provider prior to service, including:

- Include INN and OON deductibles and the INN and OON out-of-pocket max on the ID Card.
- Count all cost-share toward plan deductible and out-of-pocket max unless the member agreed to receive out-of-network care.
- Cap member cost-share at the plan's network cost-share level.
- Provide estimate of cost of care and member cost-share if member chooses to go out-of-network.
- Provide information to members on how to receive the items and services in-network.

Are there requirements that must be included on ID cards?

Yes. Insurers and health plans must include the INN and OON deductibles and out-of-pocket max on the member's ID Card.

When will insurers and health plans receive more information to assist in implementing the No Surprises law?

The Departments of Health and Human Services, Labor, and the Treasury will clarify certain provisions of the No Surprises Act though rulemaking later this year.