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An Introduction to the No Surprises Act

By Emily Madoff

Introduction

A surprise medical bill is one received by an insured patient for services rendered by a health care provider, or in a medical facility, that is out-of-network to that patient's insurance plan, but the patient reasonably could not have known the provider was out-of-network. Surprise medical bills occurred most often in emergency, air ambulance, and in-network hospital settings. The No Surprises Act ("NSA"), effective January 1, 2022 and previously enacted with bi-partisan support, restricts the surprise billing of insured patients by out-of-network healthcare providers.

Prior to the passage of the NSA, many states had enacted laws to protect consumers from surprise medical bills, but even in those states, significant gaps remained. Specifically, the federal Employee Retirement Income Security Act of 1974 (ERISA) prohibits states from adopting surprise-billing protections for consumers with employer-sponsored health insurance plans that are self-funded by the employer, although a few states allow self-funded plans to opt into state protections. In addition, the Airline Deregulation Act blocked states from enacting effective protections for those using air ambulance services. The NSA establishes nationwide protections in both of these circumstances.

What Is A Surprise Bill

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The "surprise" element is threefold, because:

1 The patient, who went to an in-network facility, had no knowledge that the provider in that facility was out-of-network until they were billed. This is because patients have no opportunity to choose these out-of-network providers. These providers do not disclose what "physician group" they're a part of, or the insurance coverage their physician group accepts, if any.

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2 The patient had no access to the out-of-network provider's prices before services were rendered. This is because these prices are not disclosed anywhere.

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3 The patient had no warning that the out-of-network provider's prices would be so high. This is because the out-of-network provider's chargemaster rates have no relation to the actual costs of delivering care and are entirely manufactured by medical providers who take advantage of not having to disclose their rates; and want to keep these rates artificially high to provide them an advantage in negotiations of network agreements with insurance companies.

Surprise balance bills have serious consequences. Because of the hefty size of the bill, the bills accrue interest over time, and medical providers often turn unpaid medical debt from surprise bills over to collection agencies. This (i) would adversely affect a patient's credit score, (ii) would remain on their consumer credit report for up to seven years, and (iii) could result in wage garnishment (a portion of the patient's employment compensation comes out of their check to pay the doctor).

How Does the NSA Curb Surprise Bills

The No Surprises Act is very beneficial to consumers as it removes patients that are insured in healthcare plans from any surprise bill disputes, and requires the health care provider and health insurer to work out the billing issues between themselves.

Under the NSA's protections:

- Patients are only liable for payment of in-network cost-sharing, i.e., copayments, coinsurance, and deductibles. They are not responsible for paying the balance bill portion.
- Providers and facilities must publicly disclose the surprise billing protections available to their patients.
- Patients cannot be sent a surprise medical bill for out-of-network air ambulance transports.
- Patients cannot be sent a surprise medical bill for "emergency services" by out-of-network providers.
- This includes emergency services that become necessary during the provision of non-emergency services.
- The NSA has broadly defined emergency services to include not only emergency department services, but post-stabilization services provided in a medical facility following an emergency visit.
- These out-of-network providers who no longer can balance bill patients may include emergency department physicians, certified nurse practitioners, physician assistants, radiologists, anesthesiologists, and more.
- Patients generally cannot be sent a surprise balance[1] bill for non-emergency medical services rendered at an in-network facility by an out-of-network provider. This includes the services rendered in conjunction with these visits, such as when an in-network provider refers a patient to an out-of-network provider for imaging services, telemedicine services, laboratory testing services, ancillary services, preoperative and postoperative services.

However:

- Patients may still receive surprise medical bills for out-of-network services rendered at an in-network facility before January 1, 2022.
- Patients may still receive surprise medical bills for ground ambulance transports, except approximately ten states have laws restricting such bills to varying degrees.
- Patients may still be responsible for paying surprise medical bills for non-emergency services at in-network facilities where the provider/facility has given written notice of the NSA protections, and patients have given written consent (usually via a signed consent form) agreeing to pay any resulting surprise medical bills from an out-of-network provider, waiving any billing protections afforded by the NSA. However, such consents and waivers do not apply under the following circumstances:
  - The provision of emergency services, anesthesiology, pathology, radiology, and neonatology;
  - Facilitative services by assistant surgeons, hospitalists, and intensivists;
  - Diagnostic services by radiologists and laboratory services; and
  - Services rendered by out-of-network providers when there are no other in-network providers to provide the relevant service in that facility.

It is important to remember that completion of these consent forms to be treated (and billed) by an out-of-network provider is entirely up to the patient. If a patient refuses to sign the relevant form, healthcare providers and facilities may refuse to provide non-emergency services, or post-stabilization care.[1] However, if they agree to treat the refusing patient, the protections of the NSA will continue to apply.

Patients will still receive large medical bills for willingly/knowingly going to an out-of-network provider or an out-of-network facility.

How is the Out-of-Network Providers' Reimbursement Determined

Typically, the amount an out-of-network provider receives pursuant to the terms of an insured patient's medical plan is only a fraction of that provider's chargemaster rate. Before the NSA, medical providers would charge the patient for the balance (hence the term "balance bill"), but the NSA put an end to that. Now the provider must look to the patient's health insurer to recover any additional sums.

As there is no pre-existing reimbursement agreement between the health insurance company and the out-of-network provider, the NSA provides a formula for determining an initial reimbursement amount and a system for disputes. Pursuant to the NSA, an out-of-network provider rendering services to an insured patient under circumstances within the purview of the NSA is entitled to be paid the Qualified Payment Amount ("QPA"). The QPA is defined as the median of the contracted rates recognized by the insurer for that service provided by the same or a similar provider in the same or similar geographic region. Health plans must pay the medical providers or facilities the total amount the plan believes it owes them (that is, their determination of the QPA) within 30 days of receipt of the provider's claim. The out-of-network provider may accept this amount (plus the insured patient's allowed cost-sharing amount) as payment in full or may dispute the amount.

If the provider challenges the amount and they and the insurer cannot reach an agreement as to the reimbursement within a 30-day negotiation period, the NSA establishes a federal independent dispute resolution ("IDR") process to resolve these payment disputes. If the provider initiates the IDR process, both the provider and the insurer 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. However, IDR arbitrators must not consider the provider or facility's usual and customary charge or the billed charge, which are generally much higher than in-network rates, or the reimbursement rates paid by public payors (such as Medicare or Medicaid).

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1 The rule applies to post-stabilization care, in relevant part, where:
-The patient is stable enough to travel without an ambulance to a nearby in-network provider/facility with availability; or
-The patient or their authorized representative is found to be in a condition where they can receive information and provide informed (written or unwritten) consent.

The arbitration is a binding “baseball style” one, in which the arbitrator chooses one of the two proposed payment amounts as the amount of the payment. The arbitrator cannot come up with their own payment amount. Arbitrators are paid through fees assessed to the entities that use the IDR process.

Conclusion

The NSA appears to be successful in protecting patients from surprise balance bills and in removing patients from the battle over the difference between what was billed by the health provider and what was initially paid by the patient’s insurance plan.

That said, the roll-out of the payment plans between the providers and the payors (that is, health plans and insureds) has not gone as smoothly. Providers have initiated lawsuits challenging the process for determining final payments for covered out-of-network services and challenging the federal agencies implementation of the independent dispute resolution process. In addition, health care providers have initiated lawsuits seeking court enforcement of awards they have won. In order to comply with the decisions in some of these cases, the federal government has made, and continues to make, changes to the IDR process. Nevertheless, insofar as the NSA was enacted to protect consumers against surprise balance billing, the act is fulfilling its purpose.


Emily Madoff

About the Author

Emily Madoff is the Managing Partner of Wolf Popper LLP.

Throughout her career, Emily has used the law to drive socio-political change, often protecting the public from consumer fraud. Emily recently focused on the rampant problems with surprise medical bills; she was instrumental in developing the Firm’s cases in this area, several of which have settled with full recovery for the class. Emily presently is concentrating on using the law to expedite the benefits of diversity and inclusion.

A commercial attorney, Emily was mentored by Marty Popper, eventually inheriting his practice. As such, Emily has represented several missions to the United Nations and various governments and government officials. She is proud to have represented personally some early social justice luminaries, such as Freda Diamond and Ring Lardner Jr. To this day, Emily represents the Georgian artist, Zurab Tsereteli, an internationally-acclaimed monumentalist and UNESCO Goodwill Ambassador, whose works are installed worldwide, including “Good Defeats Evil,” which statue sits on the front grounds of the United Nations headquarters in New York City. The Tsereteli family owns the largest winery in Georgia, producing Tsereteli Wine.

Emily has published many articles about the law, including for the New York Law Journal, an article explaining litigation funding (Analyzing the Fundamentals of Litigation Funding, August 19, 2013) and one about arbitration clauses in consumer contracts (Mandatory Arbitration Clauses in Consumer Contracts, July 5, 2016) and for Latin Lawyer, an article about the securities litigation spawned in the United States as a result of the Petrobras scandal in Brazil (Bringing 'big oil' to the Big Apple, March 2015), for a few examples.

Ms. Madoff is a graduate of Connecticut College (B.A., 1973), and Northeastern University School of Law (J.D., 1979). She is admitted to the Bars of the State of New York, the Commonwealth of Massachusetts and the United States District Court for the Southern District of New York.

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